An Eco-Systemic Addiction and Mental Health Treatment Model

NEW YORK STATE
ADDICTION TECHNOLOGY TRANSFER CENTER
Professional Development Program, Rockefeller College
University at Albany, State University of New York
135 Western Avenue, Draper 314
Albany, New York 12222

NEW YORK STATE OFFICE OF ALCOHOLISM
AND SUBSTANCE ABUSE SERVICES
1450 Western Avenue
Albany, New York 12203

Produced under a grant funded by the Center for Substance Abuse Treatment,
Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services
Center for Substance Abuse Treatment, 5600 Fishers Lane
Rockwall II, Suite 621, Rockville, Maryland 20857, 301.443.5052
Contents are solely the responsibility of the authors and do not
necessarily represent the official view of the agency
Grant No. 5U98T100850-05

CSAT
Center for Substance
Abuse Treatment
SAMHSA

The annotations contained in this manual reflect the views of their authors and should not be construed as representing the official views of the New York State Addiction Technology Transfer Center (NYS ATTC), the Department of Health and Human Services' Center for Substance Abuse Treatment (CSAT), the New York State Office of Alcoholism and Substance Abuse Services (OASAS), or the Nelson A. Rockefeller College of Public Affairs and Policy, Professional Development Program (PDP).

Summary Report:

An Ecosystemic Addiction and Mental Health Treatment Model:

Training Module and Evaluation

Addictions and Special Populations: Teaching Experience

Produced by Cheryl E. Whitley and Richard H. Gelb

The goals for the faculty fellowship year 1999 were as follows:

1. Development of a training module: An Ecosystemic Addiction and Mental Health Treatment Model

2. Provision of two in-service training sessions to provider agencies based upon the module

3. Teach the module as part of the Addictions and Special Populations course at Marist College

4. Develop and field test evaluation components for the module

5. Produce a trainer guide for the module

6. Develop a syllabus for the Addictions and Special Populations course

7. Teach the Addictions and Special Populations course with direct participation of treatment providers for dually diagnosed clients

8. Maintain a teaching log

9. Document student outcomes in the Addictions and Special Populations course

10. Share the project with the members of the Marist College School of Social and Behavioral Science

11. Share the module and evaluation findings within a professional forum

New goals emerged and were carried out within the process of the project as follows:

12. Conceptualize factors that affect utilization of training

13. Review the literature related to utilization of training

14. Develop an instrument to evaluate utilization of training

15. Field test the instrument to evaluate utilization of training

16. Summarize and report these findings above at a professional conference

Over the course of this year, the faculty fellowship recipients, Cheryl Whitley and Richard Gelb, have collaborated in the development, delivery, and evaluation of An Ecosystemic Addiction and Mental Health Treatment Module as well as the organization and first offering of Addictions and Special Populations, a three-credit college level course. While each recipient took primary responsibility for specific areas of the work, the recipients worked closely on all phases of the project. Dr. Whitley took primary responsibility for development and teaching of the Addictions and Special Populations course. Mr. Gelb developed and taught the Ecosystem Module. Both Dr. Whitley and Mr. Gelb developed and field tested the evaluation component of the project. A new area of inquiry emerged from their work, exploration of factors that affect utilization of training.

The Training Module, Ecosystemic Addiction and Mental Health Treatment, took shape over the entire year and was presented in different settings in various stages of development. The Module is a synthesis of perspectives drawn together by Mr. Gelb. This fellowship provided the incentive for him to integrate his clinical, administrative, intellectual and training experiences. The training sessions he conducted included "Families and Beliefs"and "Ecosystemic/Family Systems Treatment Model" at the Nyack Hospital Recovery Center outpatient center on February 9 and 26; "Ecosystemic practice with dually diagnosed clients," a teaching module within the Addictions and Special Populations course at Marist College on March 11; a collaborative day long training experience at Nyack Hospital for the Marist College students in the Addictions course on March 25; "Families, Beliefs, and Recovery" with a genogram consultation at the Recovery Center outpatients' facility April 22; "Ecosystemic Addiction and Mental Illness

Treatment Model" at Orange County Double Trouble Task Force meeting May 19; "Nyack Hospital Integrated Dual Diagnosis Treatment Program" at the Dutchess County MICA Task Force on May 21; "Nyack Hospital Treatment Program for Methadone Patients" at Beth Israel Medical Center, New York City, June 25, and Grand Rounds presentation of the full module on July 9 at Nyack Hospital.

Development of the module was an intellectual adventure for Mr. Gelb. It allowed him to add a new dimension to his already diverse professional repertoire that of an educator. This experience was both challenging and exhilarating. Mr. Gelb had taught as a clinician in the field who shared his case experience. Now he was able to draw together his clinical, administrative, entrepreneurial, and teaching roles. The outcome was a well conceptualized as well as dynamic training presence. Importantly, he was engaging his staff at Nyack Hospital in the processes of developing a truly ecologically oriented approach to providing services. As he conveyed his ideas articulately, staff caught his enthusiasm and began to actively enact changes. This process is ongoing.

Dr. Whitley, Mr. Gelb, Ms. Annette Bonet, Dr. Sherry Dingman of Marist College, and Ms. Tamiko Bell, graduate student at Marist College, developed and field tested the evaluation component for the Training Module, Ecosystemic Addiction and Mental Health Treatment. The first round of evaluation took place at the Double Trouble Task Force at Orange County. Major revision of the instruments resulted in a rank-order test to determine whether the training produced immediate shifts in perception of importance of specific aspects of assessment and treatment services for dually diagnosed clients. This instrument, a pre and post-test format, was field tested at the July 9 Grand Rounds and on September 24 at a staff in-service training at

Dutchess County Department of Mental Hygiene. Dr. Dingman set up and ran the statistical analysis using the Statistical Package for the Social Sciences (SPSS). Preliminary results of the first field test yielded statistically significant evidence of the module's effectiveness. Participants were also given the opportunity to provide open-ended feedback concerning the module on both these occasions.

Dr. Whitley taught the first offering of the Addictions and Special Populations Course at Marist College within the Social Work Program in the Spring term, 1999. This course was developed under a faculty fellowship from the Addictions Technology Transfer Center in 1998. Eighteen students participated in an adventure on the cutting edge of new developments in the treatment environment. They are entering the field of addictions as mental health and addiction services are converging in a shared culture that recognizes the needs of clients suffering multiple disorders within complex community and treatment environments. Teaching by treatment providers enriched the course. Presenters included Martha Mashburn, CSWR, then the coordinator of services to mentally ill, chemically addicted clients, and Mary Phillips, M.S., CASAC, both of the Dutchess County Department of Mental Hygiene, Steve Shevlin, MSW, Director, Signs of Sobriety, Ewing, New Jersey, Cheryl Conley, patient advocate, Orange County, Richard Gelb, Director, Nyack Hospital Recovery Center and co-recipient, and Dr. Sherry Dingman, PhD, psychologist, Marist College Psychology Department.

The students who traveled to Nyack Hospital for a day at the Recovery Center experienced a greater understanding of the meaning of the ecological approach to treatment and recovery. At Nyack Hospital, the visiting students heard Dr. Steven Kipnis, M.D., clinical director, Nyack Recovery Center, Annette Bonet, then Admission Coordinator, and Anthony

Porter, MSW, Outpatient Director, who applied an ecological perspective to their own work with dually diagnosed clients. Students participated in a patient "beliefs group," where a sharing process enhances patient recognition of their role in recovery within a wider community environment. Staff, patients, and students shared their beliefs about change. Students sat in on staff rounds and were amazed by the diversity of points of view that meshed to create a treatment plan and process.

The Signs of Sobriety program in New Jersey is an important resource not only for the deaf addicted but also for professionals who want to participate in an often neglected dialogue between the hearing and the deaf. Steve Shevlin's speaking to the class as a person who has experienced late onset deafness was remarkable for the students. Many said afterward that they want to learn to sign and work with the deaf addicted as part of their vocations.

Having been immersed for the past year in the processes of integrated treatment for clients with multiple diagnoses, Dr. Whitley has a firmer grasp of the complexities and realities of treatment and its delivery. She has gained from the luxury of listening to presenters in her own course as well as from continuous dialogue with her co-recipient. Being "behind the scenes" of a treatment facility has been a privilege that has enlivened her views and her teaching. She has a grasp of the content necessary to teach the Addictions and Special Populations course that is scheduled for a second offering. Next Spring, students will not only hear from the experts who have graciously offered to return, but will write and discuss the material so that it becomes integrated.

Faculties in the School of Social and Behavioral Sciences received a letter summarizing the activities of the ATTC fellowship and the resources available to them from ATTC. They also

received the ATTC Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice and information fliers about ATTC. This packet has been well received by faculty and promises to yield further activity and interface concerning resources and issues.

Dialogue between Dr. Whitley and Mr. Gelb uncovered an under studied issue, the utilization of research. Whether staff utilize training is a major issue for both staff and administrators. In order to begin discovering the factors that predict use of training, Dr. Whitley conducted two focus groups at Nyack Hospital with Mr. Gelb absenting himself. One focus group followed a staffing session and included members of all the disciplines at the hospital, medicine, nursing, alcohol and substance abuse counseling, social work, and psychology. The other was conducted at the Nyack Hospital outpatients' facility. The results are included in this packet. Those results were mined for factors that were then included in the instruments used to evaluate the training module. The instruments have been field tested twice. The intent now is to do follow up calls to begin to correlate use of the eco-systems training and predictive variables. A literature review is underway.

Summary of our work includes both content and process. Mr. Gelb has created his module, An Ecosystemic Approach to Addiction and Mental Health Treatment. He has carried out extensive training and program development throughout the year. Dr. Whitley consulted in the educational formatting of the module. She wrote a draft discussion of the evaluation processes and of utilization factors. A preliminary literature review related to utilization of training is included. Dr. Whitley has provided the teaching log, new overheads, and other resource material for the Addictions and Special Populations course.

Outcomes of this fellowship will be ongoing. Additional placements will be developed

for Marist College students at addiction treatment sites. The module itself will be further developed. Cheryl Whitley and Richard Gelb will present the module, findings from the training evaluation process, and the investigation of utilization of training at the November 1999 conference of Alcoholism and Substance Abuse Providers of New York State. The course Addictions and Special Populations will be taught again in the Spring 2000. Study of factors related to utilization of training will continue. The ecological approach will be further developed at the Nyack Hospital Recovery Center. The conceptualization of the ecosystemic approach to practice will be deepened. Working relationships between providers and educators will be built for the benefit of both students and patients. The classroom will be host to the realities of addictions work and providers will have the means to disseminate best practice.

The recipients thank the Addiction Technology Transfer Center and her staff for the opportunities for personal and professional growth that have been realized as a result of this fellowship. We especially thank Dr. Gail Viamonte for her support and guidance throughout the year.

Workshop/Seminar Description:

An Ecosystemic Addiction and Mental Health Program for Multi-diagnosed Patients/Consumers and Their Families

Introduction:

This presentation of an ecological treatment model for multi-diagnosed patients/consumers and their families focuses on the use of a contextual systems perspective to help understand and treat clients with multiple problems. The model bridges core medical, psychiatric, social work, nursing, and recovery principles, beliefs, practice realities, and strategies.

The Ecosystemic Addiction and Mental Health Model is an innovative treatment approach for multi-diagnosed patients and their families, who present with complex medical, addictive, psychiatric, and psychosocial problems. These multi-diagnosed consumers and their families have been stigmatized and denied access to treatment. They can benefit from an integrated inpatient addiction and mental health rehabilitation treatment program that combines detoxification, stabilization, and rehabilitation addiction and mental health treatment principles in a safe and secure medically/psychiatric supervised environment.

This treatment approach uses an ecological perspective that takes into account contextual systems, subsystems, referent, patient, family and care giver values and beliefs about addiction and mental illness, integrated treatment, and recovery. Additional contextual aspects of the client's social environment include medical, economic, program or agency, community, and family systems.

The Ecological approach has potential to remedy present day linear cause and affect thinking that leads to treatment program structures and policies focused entirely on changing client consumer behavior, beliefs, and personality, while neglecting the social environment of the client. Among the important ecological systems are the referring agents, families with their beliefs, hopes, and fears and behaviors, racial and ethnic culture and class. Last to receive focus for change may be the treating agency and its staff. The application of the Ecosystemic Model sensitizes staff at every level to the continuum of care, an ecological way of thinking about assessment, treatment planning, and intervention. The model also lends itself to conceptualizing the structural, emotional, and policy barriers to delivery of best treatment practices.

Workshop Outcomes and Objectives:

Participants in this workshop will:

- Understand how a widened Ecological perspective helps to address the multi-diagnosed patient's complex medical, addiction, psychiatric, and psychosocial problems.
- Develop and use an Ecosystemic format for planning and decision-making in admission, treatment, and aftercare for multi-diagnosed consumers and their families.
- Prepare family assessments, genograms, and ecomaps for use in producing positive organizational, care giver, patient, and family behavioral change.

Logistics:

Room size - accommodate 20 to 25 participants

Arrange chairs in a circle to facilitate discussion

Materials and equipment - easel, tear sheets, markers, an overhead projector

Handouts

Genograms - refer to McGoldrick, M. & R. Gerson (1985). Genograms in family assessments, New York: Horton.

Ecomaps - Hartman, A. (1978). Diagrammatic assessment of family relationships, Social Casework, 59, pp.465-476.

See Sample Ecomap/Genogram in this module or use one from your own practice.

Transparencies - make copies of any sections which will be used in training.

An Ecosystemic Addiction and Mental Health Treatment Model

Begin the program by introducing yourself, i.e., current position, credentials, world-view and beliefs about addiction, mental illness, integrated treatment, recovery, and change.

Ask participants to introduce themselves addressing the same points above, and take the time to process the participants' comments. Ask for volunteers to write the answers on the tear sheets and to write a list with answers.

Provide the following definitions with your own elaboration and explanations, i.e., for ecology, the example of the use of insecticides to kill mosquitos resulted in the pollution of the water and death of the fishes.

Ecology -"A branch of science concerned with the interrelationship of organisms and their environments; the totality or pattern of relations between organisms and their environment." (Webster's Ninth New Collegiate Dictionary p.395)

Ask participants for their definitions and have volunteers write on a tear sheet and on a list.

Ecosystem - "The complex of a community and its environment functioning as an ecological unit in nature." (Webster's p.395)

Ask participants for their definitions and have volunteers write on tear sheets and on a list.

Linear - "Involving a single dimension; having or being a response or output that is directly proportioned to the input." (Webster's p.694)

Ask participants for their definitions and have volunteers write on a tear sheet and on a list.

Read the introduction to this training seminar to the participants and discuss how you work professionally, i.e., individual, group, family, interdisciplinary, or ecosystemic models. Ask participants to describe how they work, and their thoughts on using an ecosystemic model. What are the pros and cons? Important for the trainer to read references and have knowledge and understanding of the concepts, especially Auerswald, Germain, and Keeney.

Patient/Consumer Context: Knowledge, beliefs, and attitudes:

Goals: Demonstrate competency in understanding and recognizing how patient's diagnosis, motivation, and beliefs comprise an important context in an ecological approach for integrated treatment of multi-diagnosed consumers.

Objectives:

Participants will

- **gain knowledge of dual disorders terminology**
- **become familiar with the reasons dually diagnosed consumers enter treatment**
- **gain an understanding of the difficulties consumers with co-occurrent disorders have making behavioral changes**

References:

Minkoff, K. (January 1998). Report of the Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project.

Prochaska, J., DiClemente, C., & Norcross, J. (September 1992). In Search of How People Change, American Psychologist.

Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse, Treatment Improvement Protocol Series, 9, USDHHS, 1994

Definitions:

- **Dual Diagnosis - "common, broad term that indicates the simultaneous presence of two independent medical disorders." (TIP, 9, p.4)**
- **Dual Disorders - "denotes the coexistence of two independent (but invariably interactive) disorders..." (TIP, 9, p.4)**

Patient Context, page 2

Additional Terminology and Examples of Dual Disorders: (TIP, 9, p.4., 1994)

"Combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and poly drug addiction with schizophrenia, and borderline personality disorder with episodic poly drug abuse."

"Combinations of AOD problems and psychiatric disorders vary along important dimensions, such as severity, chronicity, disability, and degree of impairment in functioning."

"Patients with mental disorders have an increased risk for AOD disorders, and patients with AOD disorders have an increased risk for mental disorders."

"Patients with dual disorders often experience more severe and chronic medical, social, and emotional problems."

Issues:

- Access to treatment for consumers is difficult due to the time-consuming and complicated procedures and paperwork used to screen patients for admission.
- Continuum of care is not integrated. The different requirements of addiction and mental health providers results in additional burden on consumer to negotiate system and solve problems.
- Limited number of community residential beds and lack of peer support creates barriers.
- Patients have been denied admission to addiction and mental health programs due to the program limitations and have not had an opportunity to benefit from either inpatient and outpatient integrated dual diagnosis treatment.
- As a result, many patients are unfamiliar with the treatment philosophy and approach of dual disorder rehabilitation treatment programs. They also experience difficulty with the rules and regulations of these alcohol/chemical dependency programs.
- These patients often times have no prior knowledge of the disease concept, recovery lifestyle, twelve-step support, or the process of rehabilitation.

Patient Context, page 3

Special Issues of Dually Diagnosed Methadone Maintenance and Opioid Patients:

- Being accustomed to methadone maintenance outpatient programs which have a simple structure and minimal rules including:

  - clinic change/days of operation
  - methadone dose
  - urine toxicology rule
  - pick-up frequency and behavior

Reasons people with co-occurring disorders may seek treatment:

- Mandated by court, probation, child protection agency, psychiatric outpatient, community residence, and methadone program
- Relapsed and referred by detoxification or sobering up unit
- Psychiatric decompensation and referred by M.D., crisis center, or hospital
- Homeless
- Family problems
- Health Deterioration
- Loss of benefits (SSI, SSD, PA, Medicaid)

Patient Context, page 4

Reasons people with dual disorders may have difficulty seeking and engaging in treatment:

- Denial of illness
- Shame resulting from the stigma of the illnesses
- Cognitive difficulties
- Overwhelmed with AOD and mental illness
- Unable to negotiate system of care and requirements for admission
- Resistance to recognizing problems
- Unable to make commitments
- Lack ability to be introspective
- Distrustful

Importance of Consumers beliefs about addiction, mental illness, change, and recovery:

Examples of consumers beliefs shared in treatment setting:

"Addiction can be stopped, mental illness can be healed."

"I believe I can recover."

"Change is what you make it."

"Mental illness and addiction go hand in hand."

"Recovery is the best thing ever!"

"My beliefs about recovery are that you have to want it, and do it for yourself, not for any other reason."

"Addiction is a disease, deadly, and leads to mental illness."

"Really have to work hard on drug addiction and staying clean. It's a lifetime effort, rocky road...mental illness is a disease, sometimes you get well, sometimes you don't...lifelong struggle."

"Very hard and unfortunate to be addicted; mental illness can be helped."

"Very difficult commitment to be in recovery, but it can be done."

"I know addiction is a disease, and I have it. I am struggling to deal with my mental illness but I am trying to work it out...it is hard to accept."

"Recovery works ...it saved my life."

"Change is when you want to do things differently and lead a different life."

See "Consumer Beliefs Questionnaire"

Questions from Nyack Hospital Consumer Beliefs Questionnaire:

"Beliefs are what you believe in your heart of hearts."

1. **What are beliefs about addiction/chemical dependency?**
2. **What are your beliefs about mental illness?**
3. **What are your family's beliefs about addiction/chemical dependency/mental illness?**
4. **Are your family's beliefs the same or different from yours? Explain.**
5. **How have your beliefs about addiction/mental illness changed since entering treatment?**
6. **What changes in your beliefs about addiction/mental illness do you want to make?**
7. **What changes in your beliefs and behavior are you willing to make in order to be a survivor?**

Patient/ Family Subsystem and Context:

Goals: The participant will demonstrate understand and recognize the importance of the family context/subsystem in the application of an Ecosystemic Model for treatment of dual disorder consumers and their families.

Objectives:

Participants will:

- **recognize how family beliefs, customs, and attitudes about addiction, mental illness, treatment, and recovery impact on integrated dual disorder treatment.**
- understand that the recruitment and involvement of families is an important element of an ecological treatment model for dual diagnosed consumers.
- consider changing their beliefs and behaviors and engage families in treatment in order to let families tell their stories and begin the healing process.

References:

Wright, L. Watson, W. L. & Bell, J.M. (1996). Beliefs: The Heart of Healing in Families and Illness. New York: Basic Books.

Papp. P. & Imber-Black, E. (1996). Family Themes: Transmission and Transformation, Family Process, Vol. 35 pp. 5-20.

Wermuth, L. & Scheidt, S. (1986). Enlisting Family Support In Drug Treatment, Family Process, 25 (25) pp. 25-33.

Hartman, A. (1978). Diagrammatic Assessment of Family Relationships, Social Casework, Vol. 59, pp 465-476.

Patient/ Family Subsystem and Context, page 2

Principles:

- Patients are often protective of family and do not want to cause further upset or conflict, and/or are cutoff from the family and do not have contact.
- Addiction and mental illness are shame based illnesses; therefore families are defensive and sensitive to the stigma. They often avoid contact with the consumer and the treatment system.
- Family members are often in a dilemma or ambivalent about being involved with the patient in part because the family fears enabling the patient or being viewed as enabling the patient. If they are cut off from the patient and something serious happens, they are left feeling guilty for abandoning the consumer.
- Families have their own beliefs about illness and recovery and ideas about what type of treatment is successful.

Examples of family beliefs gleaned from the treatment environment:

"There is a cure if you want it"

"Our daughter would be a wonderful person if in recovery"

"It's a disease , needs to be treated as a disease, and treatment and recovery are important"

"It is a very hard and unfortunate thing to be addicted and mentally ill, but they can be helped"

"For mental illness therapy, medication, and structure is needed"

"It is a never ending start and stop process"

"We are pessimistic"

"Difficulty understanding disease concept"

"We are discouraged but believe that a program will help"

"Change occurs as part of a spiritual connection with other people"

Patient/ Family Subsystem and Context, page 3

Recruitment Principles:

- Many families have experienced significant losses and suffering, and are afraid becoming involved in treatment will open up some of the pain.
- Recruitment of family for involvement in treatment requires active effort by both staff and patient.
- In order to overcome the family's belief that the illness is the patient's problem alone, the staff need to accept the family's beliefs while simultaneously attempting to discuss how those feelings may constrain the recovery of their family member with a dual disorder diagnosis.
- Families are reluctant to share their personal life with strangers because they often keep the addiction and mental illness as secrets. They are unable to confront each other to reveal the secrets.

Patient/ Family Subsystem and Context, page 4

Benefits of including families in treatment:

- Including the family in treatment provides first hand knowledge of family belief and important information about family history of addiction, mental illness, and other chronic life threatening diseases and illnesses. All this material is valuable for treatment planning and patient's progress in treatment.

- In the family sessions there is an opportunity to tell their story and share their feelings with the patient and the staff , about family themes, secrets, beliefs, values, and customs related to chronic, life threatening diseases, addiction, recovery, losses and suffering.

- The sessions are also an opportunity to educate the family, answer questions, and open up the possibilities for recovery and healing for all family members.

- Including the family in treatment serves to empower the family to change and tap into family resiliency: survival skills, spirituality, and their ability to change.

- The consumer's identifying and addressing constraining and facilitative beliefs:

    - about managing an illness, compliance with medical treatment plans and recommendations

    - about sharing feelings and experiencing the pain

    - about suffering related to having a chronic illness

- The consumer's becoming educated about the disease concept, recovery, and harm reduction

Patient/ Family Subsystem and Context, page 5

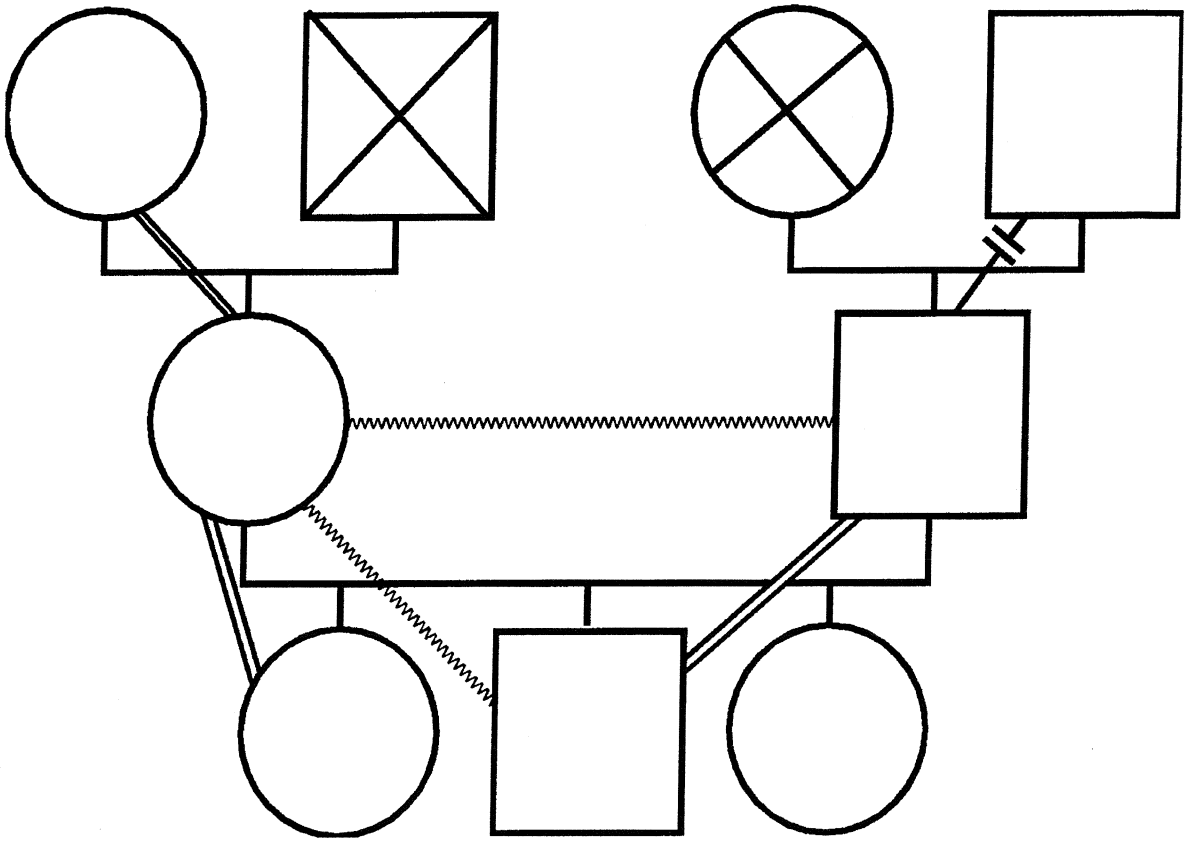
Interventions and strategies for producing change:

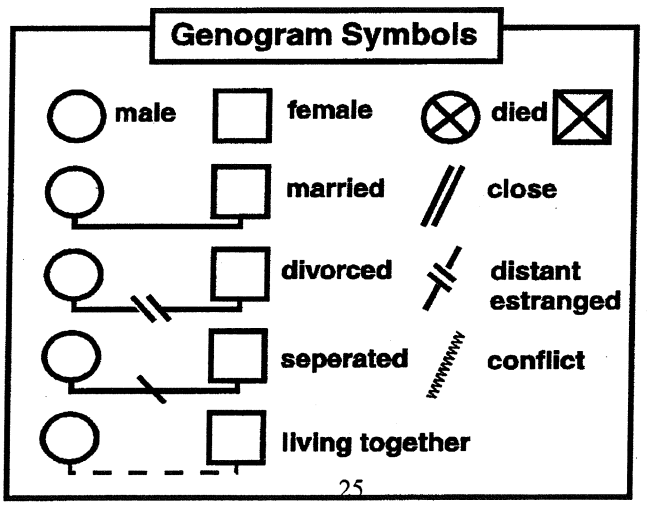
- Ask the dual disorder consumer for permission to invite the family into the treatment process.
- Contact the family and invite them in for a family meeting. This is a very powerful intervention as it broadens the focus and frames the patient's illness as a family problem.
- Welcome the family and communicate a genuine interest in joining and working with them.
- Identify the "belief that is at the heart of the matter" and begin to address constraining and facilitative beliefs, i.e., beliefs about managing an illness, compliance with medical treatment plans and recommendations, beliefs about sharing feelings and experiencing the pain and suffering related to having a chronic illness; and provide education on disease concept and recovery and harm reduction (Wright, et.al., 1996, p. 82).

"Therapeutic change occurs as the belief that is at the heart of the matter is distinguished, challenged, or solidified. ...Therapeutic change occurs through a fit between the therapeutic offerings of the clinician and the biopsychosocial-spiritual structures of family members....Change is inevitable, but the direction and pace of therapeutic change are unpredictable...Therapeutic change needs to be distinguished and languaged." Refer to Hartman, 1978 and McGoldrick and Gerson, 1985, for step by step explanation on the use of genograms and ecomaps.

Sample genogram and ecomap formats follow and the instructor should refer to Hartman, 1978 and McGoldrick and Gerson, 1985 for step by step explanation on use of genograms and ecomaps.

Sample Genogram

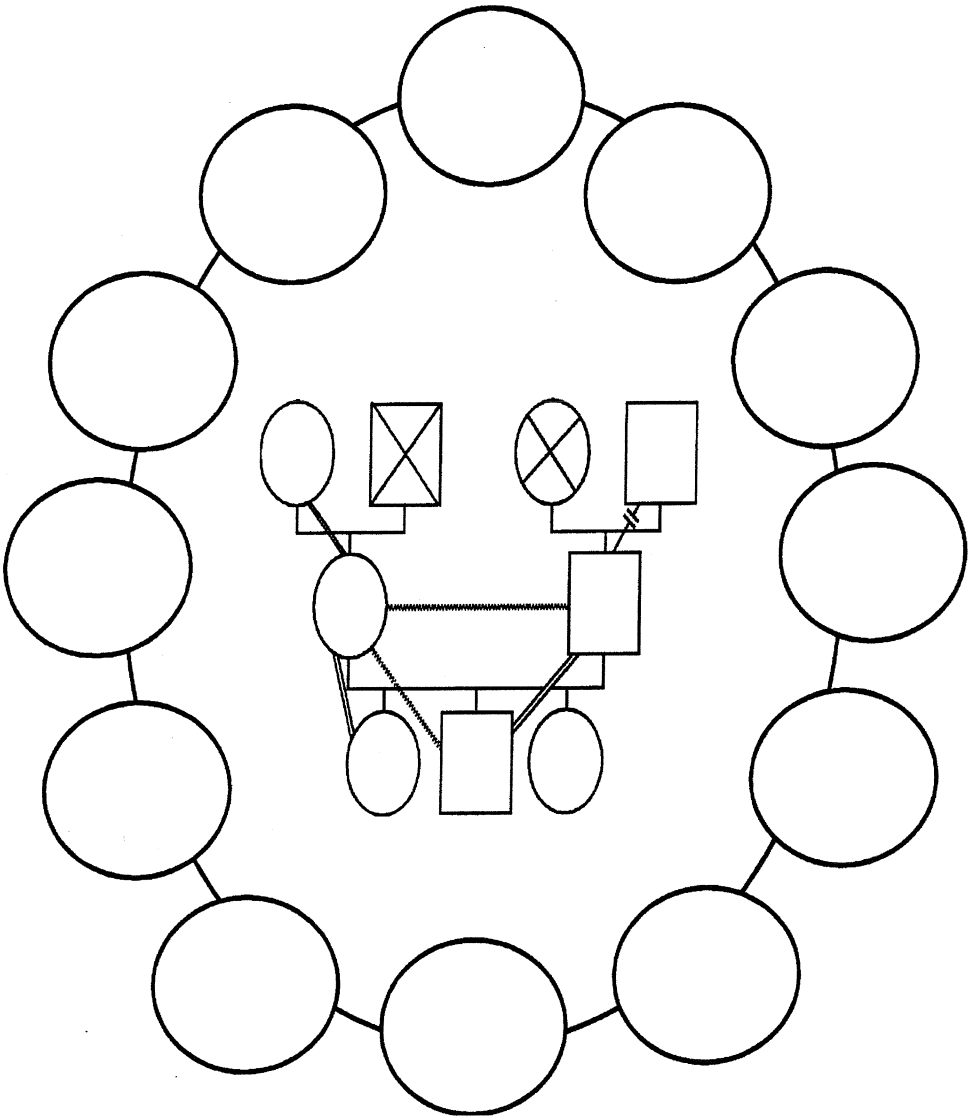




Ecomap / Genogram

Changes Patient Wants

Changes Family Wants



Beliefs, Values. Attitudes:

Patient
Family
Referent

Staff Context/Subsystem: Knowledge, Competency, Beliefs, and Values

Goal: The participant will demonstrate an understanding of the significance of staff knowledge, competency, beliefs, and values as contextual factors in the treatment of multi-diagnosed patients and their families.

Objectives:

Participants will:

- be able to assess their own dual diagnosis knowledge, competency, beliefs, and values
- recognize and describe how their competency, beliefs, and values effects their clinical work with consumers
- value the staff context/subsystem as part of the ecosystem
- demonstrate a willingness to change their behavior, beliefs, and values in order to use a ecological approach.

References:

Minkoff, K, Drake RE (eds): Dual Diagnosis of Serious Mental Illness and Substance Disorder. New Directions for Mental Health Services. No. 50. San Francisco, Jossey-Bass, 1991.

Wright, L. Watson, W. L. & Bell, J.M. (1996). Beliefs: The Heart of Healing in Families and Illness. New York: Basic Books.

Staff Context/Subsystem: Knowledge, Competency, Beliefs, and Values, page 2

Handout: Care giver's Beliefs Questionnaire

Discussion:

- What is the participant's knowledge and level of training for working with individuals with dual disorders? Ask participants to state the knowledge, training, experience and skills they need to acquire to be competent to work with this population.

Issues:

- AOD treatment program staff often have only limited knowledge of and experience with multi-diagnosed patients, and are unfamiliar with the. philosophy, purpose; rules and regulations; concepts, and value of an integrated dual diagnosis rehabilitation treatment model.

- Mental health staff have limited knowledge of and experience with AOD consumers and are unfamiliar with the AOD treatment approaches and it's value.

- Both AOD and Mental Health program staff have only limited knowledge of and experience with methadone maintenance treatment i.e. philosophy, purpose, rules and regulations, and successful outcomes.

- Important to ascertain program staff's beliefs with respect to addiction disease concept, mental illness and treatment, and addiction/mental illness as chronic relapsing illnesses requiring comprehensive treatment and a continuum of care.

- Identify the beliefs and attitudes about Opioid addiction, methadone maintenance, and use of medication for the treatment of addiction and mental illness.

CARE GIVERS BELIEFS QUESTIONNAIRE

Belief: What you believe in your "**Heart of Hearts**" to be true.

Questions:

- What are your beliefs about addiction?
- Do you believe addiction is a chronic relapsing disease/illness?
- What are your beliefs about mental illness?
- Do you believe mental illness is a chronic relapsing disease/illness?
- Is treatment effective?
- What types of treatments are effective?
- Is methadone maintenance an effective treatment?
- Is integrated dual focus treatment effective?
- Are psychotropic medications effective?
- What are your beliefs about recovery?
- What are your family's beliefs:
  - Addiction?
  - Mental illness?
  - Treatment?
  - Methadone maintenance treatment program?
- Are your family's beliefs the same or different from your beliefs?
- What are your colleague's beliefs about:
  - Addiction/mental illness?
  - Treatment?
  - Methadone recovery?
  - Are they the same or different from your beliefs?
- What are your patient's beliefs about:
  - Addiction/mental illness?
  - Same or different from your beliefs?
- Do your patients believe it is a chronic relapsing disease?
- What are your patient's beliefs about treatment, methadone recovery, and "change?"
- What are your patient's family beliefs about addiction/mental illness, treatment, methadone recovery, and "change?"
- What are the changes you, your colleagues, your patients and their families need to make in order to be 100% committed to the recovery/treatment process?
- What are your strengths?
- What your patients strengths?
- What changes are you prepared to make now?
- What are your beliefs about harm reduction?
- Can harm reduction techniques be utilized along side abstinence techniques?

Referent Context/Subsystem

Goal: The participant will demonstrate an understanding of the value of the referent context in an Ecosystemic Model by active participation in the referral process.

Objectives:

The participant will:

- describe and recognize how they function as referents.
- demonstrate changes in how they can provide information and collaborate in the referral process.
- be able to recognize the referent context in the ecosystem.

References: Wright, 1996

Discussion:

Inpatient and outpatient addiction rehabilitation and mental health programs and staff to clearly spell out their philosophy, beliefs, and strategies for accepting and providing treatment for multidiagnosed consumers.

Referent Context/Subsystem, page 2

Identify and teach the need for an ecosystemic referent process:

- Identify reasons referent has recommended AOD, dually diagnosed, and or opioid and methadone maintained patient for inpatient and outpatient integrated dual diagnosis rehabilitation.
- Identify reasons the patient wants to go treatment or rehabilitation.
- Compare referent and patient reasons for treatment. Are they similar or different?
- Come to a consensus regarding the reasons for treatment:
    - What does the referent identify as problems the patient needs to address in treatment?
    - What are the problems the patient wants to work on in treatment?
    - Are referent and patient in agreement? Where do they disagree?
- Identify what changes the referent expects and wants the consumer to make as a result of treatment.
- Identify the changes the patient/consumer is interested in making by entering treatment.
- Compare referent and patient change goals: on what changes do they agree and on what do they disagree?
- What are the referent's beliefs about integrated dual diagnosis treatment, and recovery?
- What are the patient's beliefs about treatment, and recovery?
- What are the patient's family's beliefs?
- Clarify for the referent, patient, and family, the rules, regulations, and expectations of the treatment program.
- Communicate to all involved the referent's, patient's and family's motivation for change; and the behaviors, attitude, and beliefs patient, family, and referent are willing to work on changing in order to produce positive behavioral and attitudinal change and achieve recovery.
- Assure the referent that "their" program and treatment approach will be respected.
- Inpatient and/or outpatient rehabilitation staff and program enter an agreement and contract to collaborate with the patient, the referent, and the family during the treatment process.

<u>Referent Context/Subsystem</u>, page 3

The referral of multi-diagnosed patients is Complicated and Labor Intensive:

Labs

Medical history

Psycho-social information

Psychiatric/mental status report

Financial/benefits information

Telephone interview of patient and evaluation of motivation is time consuming

Referent and family involvement in treatment

Managing Change

Goals: The participant will demonstrate an understanding of how to use an ecological approach to develop new techniques and strategies for producing system and subsystem change at the care giver/staff, patient/consumer, referent, and organization/program levels.

Objectives:

Participants will:

- **become familiar with role of program management and leadership in promoting change**
- **understand how staff attitudes, beliefs, and values are barriers to change**
- **learn how to use an ecosystemic model to manage change**

References:

Auerswald, E.H. (1983). The Gouverneur Health Services Program: An Experiment in Ecosystemic Community Health Care Delivery, Family Systems Medicine, 1(3).

Auerswald, E.,H. (1971). Families, Change and The Ecological Perspective, Family Process, 10(3).

Auerswald, E.H. (1968). Interdisciplinary Versus Ecological Approach, Family Process, 7, pp. 202-215.

Wright, L. Watson, W. L. & Bell, J.M. (1996). Beliefs: The Heart of Healing in Families and Illness. New York: Basic Books.

Discussion:

Program leadership's beliefs: Access to treatment is patient's/consumer's rights issue

- Leadership to advocate for patients/consumer right to treatment in the belief that people can benefit from treatment, change their behavior, and heal the pain and suffering related to their disease

- Program management provides the following:
  - Leadership
  - Staff training
  - Staff support
  - Funding for adequate staffing and compensation for competent staff

Managing Change, page 2

- Leadership must be sensitive to dilemmas of change, i.e., change has both positive and negative aspects, and the status quo also has both positive and negative consequences.

- Staff present a range of options available to patients to address their mental illness and addiction while respecting patient's level of motivation/stage within the change process.

- Staff need willingness to work through patient's misconceptions/beliefs regarding mental illness, addiction, integrated treatment which addresses both illnesses, the disease concept, 12 step/ double trouble programs.

- Staff are challenged not to allow professional and personal bias about multi-diagnosed patients and integrated treatment to enter into treatment of patients. All patients have the legal right to inpatient and outpatient rehabilitation treatment and full continuum of care, i.e., half-way houses, community residences, education, vocational training, job placement, etc.

- Staff's counter-transference issues are continually addressed in staff supervision, i.e., attitude and beliefs regarding abstinence and recovery, harm reduction, and feelings which are barriers to effective treatment for consumers.

- Staff maintain close contact with the referents including mental health clinics, MICA community residences, CPS, probation, and methadone maintenance treatment programs and clearly identify issues/services that need followed-up when patient returns to community based programs, i.e., follow-up for therapy services (individual/group), psychiatric medication management, medical care, twelve-step program involvement, vocational services.

- Staff are sensitized to discrimination that may take place in the patient population and they continue to reinforce/model respect for <u>all</u> patients.

- Staff and patients need to learn the importance of setting realistic/attainable goals with concrete timetables.

- The program develops levels; i.e., a range of options for patients to address addictions based on the patient's level of motivation.

- Staff works in a *collaborative/systemic model* that includes:

  Valuing, respecting, and depending on referent relationships for information and feedback.

  Sensitivity to referents' limitations and concerns; i.e., staff-patient ratios, limited clinical supervision, lack of education and training on treatment of multi-diagnosed patients.

Belief that people can change! The consumer can successfully complete the inpatient rehabilitation program, be stabilized on medication, continue with treatment at HWH or MICA community residence or return to school or work.

Developing a strength based approach which identifies consumer strengths, abilities, and resiliency.

From Lorraine Wright's book, *Beliefs, The Heart of Healing in Families and Illness*:

"We want to distinguish change, to draw it forth from its background in a manner that identifies, magnifies, and sustains change. It's all about bringing change to life!

We bring change to life in the following ways:

We are passionately persistent in pursuing change

We see what change family members are seeing and help them see more

We systemically explore change

We invite observations of other's observations of change

We systemically explore the effects of change

We invite explanations for change

We distinguish facilitative beliefs

We systemically celebrate change

We publish change

By bringing change to life, we increase the possibility for the continuing presence and influence of change in family members' lives.

FAMILY SYSTEMS EVALUATION

NOTE: YOU MUST INCLUDE EVERY ITEM. IF DATA IS LACKING, STATE PLAN FOR OBTAINING INFORMATION.

I. DATE OF REPORT

II. IDENTIFYING DATA

III. HISTORY OF REFERRAL

IV. PRESENTATION PROBLEM
- Is there conflict about why the family is coming for treatment
- What does the therapist see as the problem

V. DESCRIPTION OF FAMILY

A. **Family as a system in the present:**
Projective system, role assignments, communication, triangles, fusions, attempts at differentiation, etc.
Rigidity and flexibility

B. **Relationship of Martial Pair:**
Include history of marriage
Psychosocial history of each spouse

C. **Parent-child relationships:**
Include psychosocial history of each child or adolescent

D. **Sibling Relationships:**
Include history

E. **Relationship to extended family network**

F. **Relationship with Society**

G. **Significant medical history**

H. **Other information not included above**

I. **Brief summary of family**

VI. RELATIONSHIP TO THERAPIST
- How does therapist relate to the family and how does the family react to the therapist's interventions?
-

VII. PLANS FOR TREATMENT

A. **Current goals for family change:**
1) Short-term
2) Long Range

B. **Methods to be used by therapist**

C. **Other therapeutic modalities besides family therapy**

D. **Summary of progress in time since first seen**

Recovery Center
Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960-1998
914-348-2070 • 800-922-5535

Consumer Beliefs Questionnaire

Beliefs are what you believe in your heart of hearts.

1. What are your beliefs about addiction/chemical dependency?

2. What are your beliefs about mental illness?

3. What are your family's beliefs about addiction/chemical dependency/mental illness? Are their beliefs the same or different from yours? Explain:

4. What were your beliefs about addiction/mental illness while you were using?

5. How have your beliefs about addiction/mental illness changed since entering treatment?

6. What changes in your beliefs about addiction/mental illness do you want to make?

7. What changes in your beliefs and behavior are you willing to make in order to be a survivor?

Results from Professional
Grand Rounds

Question asked of participants

"Change Occurs" (complete sentence)_____

- **Within**
- **With motivation and support**
- **With motivation**
- **With responsibility**
- **When you make it possible**
- **With learning different things**
- **You believe it will**
- **With every new breath**
- **Whether we like it or now**
- **When people are ready and think positive**
- **Constantly and when your mind is open to it**
- **When the pain is sufficient**
- **You want it to happen**
- **You get fed up**
- **With self growth**
- **Positively when you take time**
- **Lose your pride and lose yourself**
- **Perseverance**
- **Every moment**
- **Sometimes when a person hits bottom**
- **In relationship with common goals**
- **Among people, input and output**
- **With the seasons, with the weather**
- **All the time**
- **With education and support**
- **People feel hurt and understood**
- **People believe they are worth it**
- **Constantly**
- **Inevitable**
- **Constantly..thank God**
- **In spite of**
- **As part of spiritual connection with other people**
- **Continuously**
- **Come from within**

The Thursday night family group at the Blue Hill Recovery Center discussed change occurs/is. Each individual in the group was asked to give their perception of change occurs/is. The following list are their responses.

1. good to bad; drugs to recovery
2. growing up; seeing things through different eyes
3. change in perception
4. refraining from doing past activities
5. different people, places and things
6. understanding people/problem
7. better ways
8. process
9. concentration
10. become better
11. effort
12. energy
13. growth
14. belief in self
15. what you make it
16. different view
17. helping self
18. better
19. perception
20. constant
21. respected
22. all the time/better
23. difficult to accept
24. behavior/attitude
25. new thinking
26. do something better
27. don't be afraid/fear
28. positive thinking
29. process of transcending
30. choice/growth
31. better prospective
32. good outcome
33. do something different

Thanks for sharing with the family group.

Thomas P. Gillette
Family Group Scribe

Program Development and Staff Training

A format for assessment, analysis and evaluation of the systemic and contextual issues which considers the patient/client and family's psychosocial, medical, addiction and psychiatric needs will be presented in a theoretical format. This ecological assessment will include the referent's needs and expectations, services required, treatment planning, staff roles and function and delivery of an integration program of addiction, mental illness, medical and psychosocial services to meet consumer/patient needs. All of the above requirements will be presented with clinical applications of genograms, ecomaps, family assessment forms, context checklists and analysis of change vs. status quo dilemmas.

Faculty and Provider Fellowship Program

Sponsored by

New York State Addiction Technology Transfer Center (ATTC)
Funded through
The Center for Substance Abuse Treatment
and directed by
The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS)

Richard H. Gelb, MA
Director
Addiction Services
Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960
Tel: 914 348-2073
Fax: 914 358-9085

Nyack Hospital

NYACK HOSPITAL

ADDICTION SERVICES

ECOLOGICAL ADDICTION AND MENTAL ILLNESS TREATMENT MODEL

"COURAGE TO CHANGE"

Recovery Center
160 No. Midland Ave
Nyack, New York
10960

Center for Change
Two Blue Hill Plaza
Pearl River, New York
10965

Using An Ecosystemic Approach to Enhance the Intake and Admission Process at Nyack Hospital Recovery Center Addiction/Mental Health Treatment Program

By
Annette Bonet

Using An Ecosystemic Approach to Enhance The Intake and Admission Process at Nyack Hospital Recovery Center Addiction/Mental Health Treatment Program

Although an ecological perspective is not a new phenomenon in the social sciences, only few specialized disciplines have attempted detailed, systematic study of the complex interrelationships that exist between people and their environments. Bradford P. Keeney states that "Traditionally, clinical diagnosis has been tied to the process of ascribing a label to an individual in order to signify the particular pathology and class of symptoms exhibited" (Keeney 1979). The Nyack Hospital Recovery Center's admissions process consisted of a phone screening with the patient who, responded to a set of questions placed before him/her. What the Admissions Coordinator received in return were responses that many admission professionals encounter in any treatment modality. When asked the question: "Why do you want to come into treatment at this time? The patient's responses were usually similar with many other patients:

- I'm sick and tired of being sick and tired
- My MMTP thinks I should go to an inpatient facility
- They will take away my children if I don't
- I need help
- I want my recovery

After conducting a telephone screening with patients, the realization was that:

- Methadone maintenance patients were not invested in abstinence
- Many patients were mandated to treatment by child protective services/courts
- Many pregnant women were feeling hopeless because they know the difficulty encountered in placing mothers and babies in long-term facilities (or any facilities).
- Patients who lacked education, feel shamed and also hopeless
- Many women (some men) have underlying issues (i.e.sexual abuse)
- Dual diagnosed patients have to suffer with the stigma of mental illness
- Many dual diagnosed patients have been greatly burdened by having to take medication for their disability. The use of medication has negative connotations for the mentally ill because society has stigmatized mental illness with terms like "crazy, or not normal." Society beliefs, that medication is a way of normalizing the mentally ill and without it, they may become unstable or a danger to society.
- Women are continuously faced with the stigma of entering into treatment facilities. Society has perceived notions regarding women. Women are caretakers, they are expected to raise the children, take care of the home, and be available for comfort, support, love attention compassion and selflessness. Women whom are addicted to illicit substances go against the "grain" in respect to societies expectations, and this makes it difficult for women to redeem themselves and return back to society in recovery.

- Difficulty in placing these specialized populations in long term treatment facilities (women/children, dual diagnosed and methadone maintenance patients) due to the limited number of community housing program

- Many patients believe that while addiction is a destructive force, there are no other alternatives.

Many of problems that we encountered prior to the utilization of an ecological approach were based on the lack of information from the various systems within the patient context. Without more contextual information, we were accepting admissions into the facility without having the "full picture" of the patient that we were treating, why they requesting treatment, and what systems were in place that influenced the patient either negatively or positively.

Each patient's treatment is adapted to what systems are made available to the facility. Treatment is based on the individual's substance abuse, their physical needs, their psychological needs etc., no two patients are alike, so it is safe to say that no two patients have exactly the same treatment plans. The importance of the ecological approach is the opportunity to examine each individual within the context of their environment. The ecological systems approach allows for the development of a whole new technology in the collection and analysis of information about the patient and his/her environment and in the production of change

The ecological systems approach encompasses the "entire" person within the context of their family, public/child welfare, foster care, courts, mental health clinics and all other community agencies. It examines the relationships between various other systems designed for specialized populations such as agencies mandated to provide services to offenders, probationers, parolees, the mentally and/or physically handicapped or the aged. This approach may also allow programs to include beliefs about illness, addiction, mental illness, and other diseases, culture, values and customs.

The ecological based admissions and intake process determines the most appropriate initial course of action, taking into consideration the needs and characteristics of the client and the services that are available within the community. This process must incorporate as many aspects of an ecological context and social system, which encompasses the patient, before narrowing their focus of treatment to one particular area alone. For instance, when a client is diagnosed with a mental illness, the primary focus is then placed on that diagnosis, the ability to substantiate the diagnosis and to ascertain a way to stabilize the condition.

The various other systems that make up the context of the patient are rarely examined as a precipitating factor in their illness. Social systems are inclusive of people or groups of people who interact and influence one another's behaviors. Social systems are inclusive of parents, Department of Social Services, probation, school etc. This theory stresses the need to view the immediate system being dealt with within the context of its significant environment or the social situations within which it operates. The needs of the patient must be addressed, while allowing for the various systems surrounding and touching their lives to be addressed as well. Buckley defines systems as "complexes of elements or components directly or indirectly related in a causal network, such that each component is related to at least some others in a more or less stable way within a particular period (Buckley 1967).

The Nyack Hospital Recovery Center admissions process has instituted changes in the admissions process and has adopted an ecosystemic approach. There is significant value in obtaining as much information from as many sources as possible when considering admission of a patient. It is important to have the right "fit" for patients and not to bring them into a facility that has not ascertained adequate information to treat them. The admissions process can take up to two days in deciding on the appropriateness of the facility to meet the needs of the patients. The procedure goes as follows:

1. Telephone screening with the patient:

   A) Demographics (name, address, telephone number, social security numbers, etc)

   B) Name of person referring patient to facility; why does patient believe referent is referring them?

   C) Insurance information: verification of coverage and benefits

   D) Past and present alcohol/drug use. Identification of substance, length of use, amount of usage, and the last time chemical was used by patient

   E) Previous treatment facilities, how long at facility, completion of program, length of time not using, and follow-up treatment/discharge plans

   F) Medical problems/medications taken

   G) Psychiatric history, suicide ideation, homicide ideation, diagnosis, psychiatric treatment facilities and medications given

   H) Legal actions pending (court, parole/probation [names and telephone numbers] child protection services, court appearances, offenses committed

Once the telephone screening has been completed, the patient is furnished a questionnaire. The patient's thoughts and feelings are vital in this systems approach. Their beliefs and perceptions transcend to their behavior and actions. "We have to meet the clients where they are, and not where we want them to be."

Some of the questions that are asked on the questionnaire are:

- What are your presenting problems?
- What changes do you want to make?
- What does your referring agency/individuals believe to be your problem?
- What are your beliefs about addiction/mental illness?
- What are the beliefs of your families regarding addiction/mental illness?
- How are they different/similar to yours?
- How can this program help you?
- What are your strengths/assets?
- What are your goals/objectives?
- How can we help you to achieve them?

The traditional interdisciplinary approach empowered the team to arrive at the problem and the solution. The ecological systems approach empowers the patients and the surrounding systems to arrive at the problem, what changes need to take place, and how can it be accomplished.

Once the telephone screening has been completed, a request goes out to the referring agency for documentation, which includes:

- Labs
- X-rays
- Psychiatric history/mental status
- Psychosocial
- Medication list

The process of referral of patients is considered to be crucial. It defines not only who may be involved in the evolution of the problem, but also in what way the patient is seen to be having difficulties. The referent is asked to give their assessment of the client:

- Why referent is referring patient?
- What changes do you believe are prevalent to patient's treatment?
- What do you believe are the motivating factors for patient seeking treatment?
- What do you believe are the patient's problems?
- Are you willing to assist the case manager assigned with the discharge plan for patient?

What we have encountered upon making the changes to our admissions process was resistance from many of our referents. Responses were:

- "Your facility ask to many questions"
- "Other facilities don't require so much information"
- "Other facilities don't require that the patients complete any assignments"
- Outdated psychosocials, mental status, and psychological information

Referent information is important in the initial context and in the establishing of the counseling relationship. Keeney states "The patient's symptom" and the "therapist's interventions" are seen as communications in an informational network of human relationships" (Keeney 1979). Referents disclose something about their relationship with the patient and how they might have exhausted their ability to manage the patient in some aspects of care.

Referent context is very important for various reasons:

- The referents know more about the patients then we do at the time of intake: Referent input is helpful in developing a treatment plan to meet the needs of the patient.
- The referent may be aware of what the patient's motivations are for seeking treatment. We need to be able to understand what the patient's motives are and sometimes the referents are privy to information that may not be disclosed to us during a telephone screening.

- The referent has observed seen the patient's interaction with others: Interrelationships that exist between the patient, the environment and other people can help establish the social context of the patient and the degree to which a patient's interactions are either healthy or unhealthy.

In applying the ecological systems approach to the referent context, it enabled us to collect pertinent information. The information ascertained was then utilized in gaining a clearer understanding of the needs and goals of the patients, determining whether The Recovery Center would be the appropriate facility for the individual patient, and insuring the treatment plan fits the patient's needs.

We have learned never to insist on family member's presence in treatment and have done complex systems works with the single client. Family functioning is related to the changes in the patient's progress while in treatment. It is impossible for a major part of the system to change without a complementary change in the whole, therefore there has to be interventions in place that would allow the family to be free to change. Wermuth and Scheidt state "The family can aid in recovery. Research suggests that family interventions are more effective than individual interventions in preventing relapse to drug abuse" (Wermuth and Scheidt 1986).

We realize that no one can change another human being. The thought of attempting to do so is overwhelming, because the factors involved in that change are too complicated for one facility to attempt. If we cannot change the patient's, behaviors, we most certainly cannot change their families. What the objective is, is to shift their families thinking from the addiction being the addict's problem to believing that it is a family problem. We can only help the family in identifying that they may also need to seek some level of treatment for themselves.

Some of the barriers that make family treatment difficult at times and impossible at other times are:

- Families are ashamed of the addictive member
- Families do not believe that the recovery process works/church will
- Many families are not educated on addiction and therefore do not understand anything regarding the process of recovery.
- Many families believe that once rehab is completed, the addictive person is well.
- Families believe that the problem lies with the addicted person.
- Families do not believe that they also need treatment.
- Families tell a family member to either stop or else.
- Families believe that if a member takes psychotropic medications that they are "really crazy"
- Families are ashamed of a member with a psychiatric disorder

Treatment facilities often experience difficulties involving patient's families in treatment based significantly on the beliefs and attitudes of the family. The families are one of the largest and most important systems within the context of the patient's treatment. Auerswald states that "Health and human services system is in fragments as the result of specialization. Individual people and families with complex socio-environmental, family and individuals problems have had to seek help for each individual situation. The distress of an individual human being could never be fully understood outside the socio-environmental context of his or her life, and that the most important system making up that context was the family.

Once all documentation and collection of systems data are in place, the intake is then reviewed by the Medical Director, Director, Nurse Manager and Clinical Supervisor, opting for a decision on the appropriateness of the facility in meeting the needs of the patients. In our efforts to remain effective in the treatment of addiction, and to meet the needs of our patients, we must make the necessary changes and adjustments in order to maintain a more effective treatment facility for our consumers.

Historical information offers a rich combination of facts, stories, and metaphors that can suddenly throw a new light on a set of relationships or a series of events that previously were puzzling or mysterious. If the relationships between various other aspects of the patient are ignored it may easily result in fragmented and ineffective treatment. Assessing the relationships of as many of the patient's "systems" as possible prior to admission and during the course of a assessment can assist the facility in the therapeutic endeavor and avoid treatment failures that arise when one lacks such knowledge.

References

Allen-Meares, P. & Lane, B.A. (1987). Grounding social work practice in theory: Ecosystems social work, The Journal of Contemporary Social Work, pp. 515-518.

Aponte, H.J. & Winter, J.E. (1987). The person and practice of the therapist: Treatment and training. New York: Haworth.

Auerswald, E.H. (1983). The gouverneur health services program: An experiment in ecosystemic community health care delivery, Family Systems Medicine, 1(3).

Families, change and the ecological perspective, (1971). Family Process, 10(3).

Interdisciplinary versus ecological approach, (1968). Family Process, 7, pp. 202-215.

Bor, R, Miller, R., & Perry, L. Systemic counseling for patients with AIDS/HIV infections, Family Systems Medicine 6(1).

Brown, S. & Lewis, V. (1999). The alcoholic family in recovery. New York: Guilford.

Buckley, W. (1967). Sociology and modern systems theory. Englewood Cliffs, N.J.: Prentice Hall.

Costanini, M.F., Wermuth, L., Sorensen, J.L., & Lyons, J.S.. Family functioning as a predictor of progress in substance abuse treatment, Journal of Substance Abuse Treatment, 9, pp 331-335.

Ekstein, R., & Wallerstein, R. (1972). The teaching and learning of psychotherapy, New York: International Universities.

Germain, C. The ecological approach to people-environment transactions, Social Casework, 62 (6), 323-331.

Gibson, D.R., Sorensen, J.L., Wermuth, L., & Bernal, G. Families are helped by drug treatment, The International Journal of The Addictions, 27(8) pp. 961-978.

Hartman, A. Diagrammatic assessment of family relationships, Social Casework, 59, 465-476.

Imber-Black, E. A family-larger-system perspective, Family Systems Medicine, 9(4).

Imhof, J. Countertransference issues social casework, The Journal of The Addictions, 18(4).

Keeney, B.P. (1983). Aesthetics of change. New York: Guilford.

Ecosystemic epistemology: An alternative paradigm for diagnosis, Family Process, 18(2).

Keeney, B.P. & Silverstein, O. (1986). The therapeutic voice of Olga Silverstein. New York: Guilford.

Lewis, G.L. (1991). Family systems application to social work: Training and clinical practice. New York: Haworth.

Menicucci, L.A. (1989). Expanding the family systems approach: Cultural, class, developmental and gender influences in drug abuse and HIV .

Papp, P. (1983). The process of change. New York: Guilford.

Papp, P., Imber-Black, E. Family themes: Transmission and transformation, Family Process, 35. pp.5-20.

Roche, A.M. Alcohol and drug education and training: A review of key issues, drugs: Education, prevention and policy, 5(1).

Schwartzman, J. The natural history of a drug treatment system, Family Systems Med., 4(4).

Senoy, E. (1998). Substance abuse disorders in clinical practice. New York: W.W. Norton.

Tomm, K. One prespective on The Milan Systemic approach: Part I. Overview of development, theory and practice, Journal of Marital and Family Therapy, 10(2) pp 113-125.

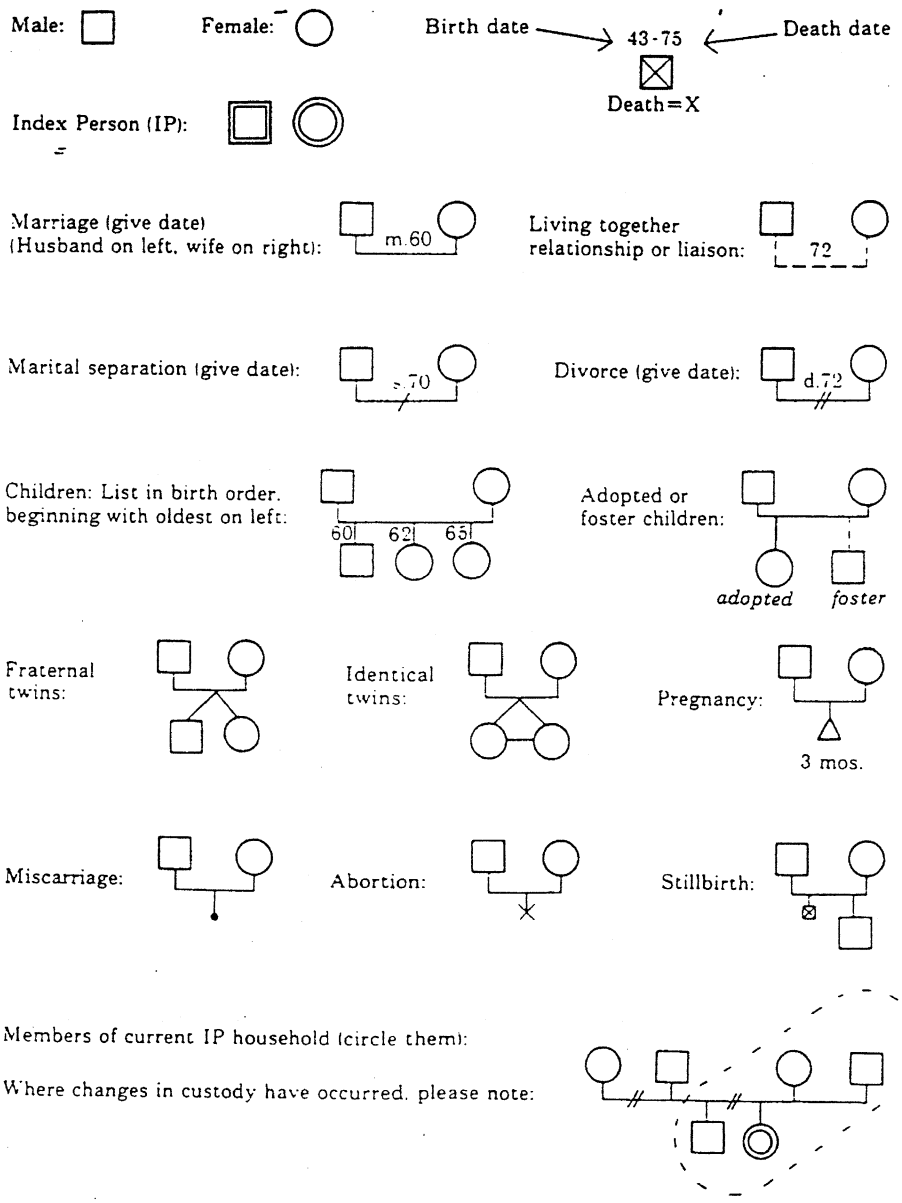
Wermuth, L., Scheidt, S. Enlisting family support in drug treatment, Family Process, 25(25) pp.25-33.

Wright, L. Watson, W.L., & Bell, J.M. (1996). Beliefs: The heart of healing in families and illness. New York: Basic Books.

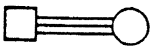
(From, Genograms in Family Assessments, McGoldrick and Gerson,1985)

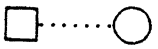
PART 1: GENOGRAM FORMAT

A. Symbols to describe basic family membership and structure (include on genogram significant others who lived with or cared for family members – place them on the right side of the genogram with a notation about who they are.)

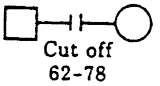


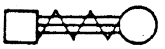
B. Family interaction patterns. The following symbols are optional. The clinician may prefer to note them on a separate sheet. They are among the least precise information on the genogram, but may be key indicators of relationship patterns the clinician wants to remember:

Very close relationship: 

Distant relationship: 

Conflictual relationship:

Estrangement or cut off (give dates if possible): 

Fused and conflictual: 

C. Medical history. Since the genogram is meant to be an orienting map of the family, there is room to indicate only the most important factors. Thus, list only major or chronic illnesses and problems. Include dates in parentheses where feasible or applicable. Use DSM-III categories or recognized abbreviations where available (e.g., cancer: CA; stroke: CVA).

D. Other family information of special importance may also be noted on the genogram:

1) Ethnic background and migration date
2) Religion or religious change
3) Education
4) Occupation or unemployment
5) Military service
6) Retirement
7) Trouble with law
8) Physical or sexual abuse or incest
9) Obesity
10) Alcohol or Drug abuse (symbol=)
11) Smoking
12) Dates when family members left home: LH '74.
13) Current location of family members

It is useful to have a space at the bottom of the genogram for notes on *other key information*: This would include critical events, changes in the family structure since the genogram was made, hypotheses and other notations of major family issues or changes. These notations should always be dated, and should be kept to a minimum, since every extra piece of information on a genogram complicates it and therefore diminishes its readability.

PART 2: GENOGRAM FORM

FAMILY NAME _____

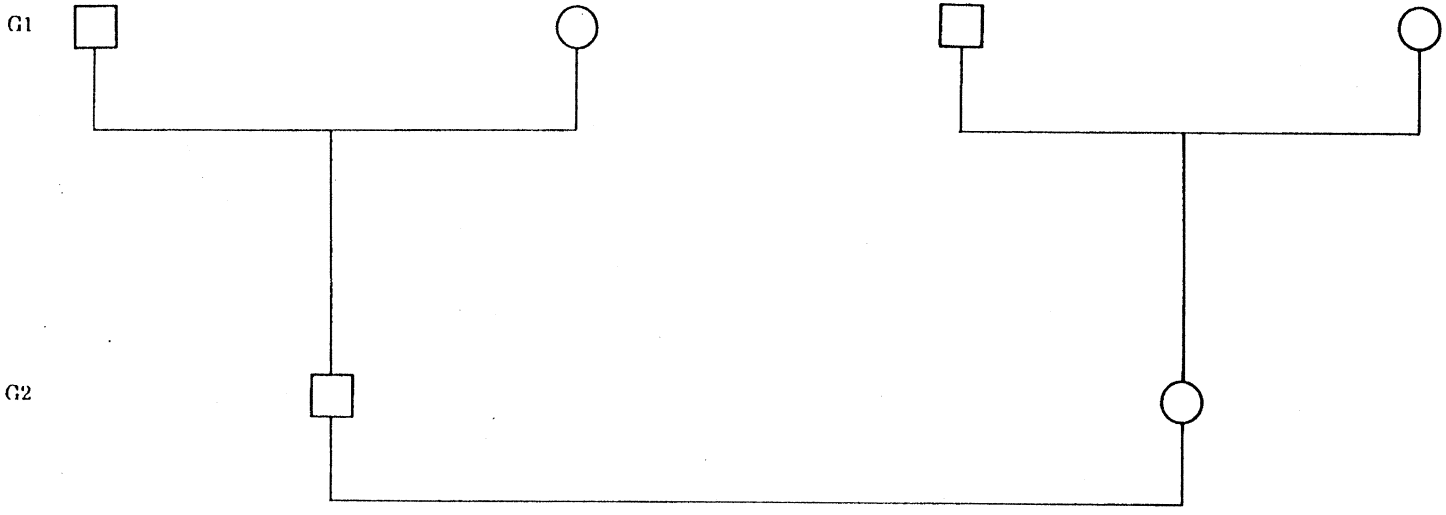
Date Filled In _____

Filled In By _____

Family Address _____

Key Hypotheses & Life Events

Significant Others



PART 3: OUTLINE FOR A BRIEF GENOGRAM INTERVIEW

Index Person, Children and Spouses

Name? Date of birth? Occupation? Are they *married*? If so, give *names of spouses*, and the *name* and *sex* of *children* with each spouse. Include all *miscarriages, stillbirths, adopted* and *foster children*. Include *dates* of *marriages, separations*, and *divorces*. Also include *birth* and *death dates, cause of death, occupations* and *education* of the above family members. Who lives in *the household now*?

Family of Origin

Mother's name? *Father's* name? They were which of how many children? Give *name* and *sex* of *each sibling*. Include all *miscarriages, stillbirths, adopted* and *foster siblings*. Include *dates* of the *parents' marriages, separations*, and *divorces*. Also, include *birth* and *death dates, cause of death, occupations* and *education* of the above family members. Who lived in *the household when they were growing up*?

Mother's Family

The names of the *mother's parents*? The mother was which of how many children? Give *name* and *sex* of *each of her siblings*. Include all *miscarriages, stillbirths, adopted* and *foster siblings*. Include *dates* of *grandparents' marriages, separations*, and *divorces*. Also include *birth* and *death dates, cause of death, occupations* and *education* of the above family members.

Father's Family

The names of the *father's parents*? The father was which of how many children? Give *name* and *sex* of *each of his siblings*. Include all *miscarriages, stillbirths, adopted* and *foster siblings*. Include *dates* of *grandparents' marriages, separations*, and *divorces*. Also include *birth* and *death dates, cause of death, occupations* and *education* of the above family members.

Ethnicity

Give ethnic/religious background of family members and the languages they spoke if not English.

Major Moves

Tell about major family moves and migrations.

Significant Others

Add others who lived with or were important to the family.

For All Those Listed, Indicate Any of the Following:

serious medical, behavioral, or emotional problems;
job problems;
drug or alcohol problems;
serious problems with the law.

For All Those Listed, Indicate Any Who Were:

especially close;
distant or conflictual;
cut off from each other;
overly dependent on each other.

PART 4: GENOGRAM INTERPRETIVE CATEGORIES

Category 1: Family Structure

A. Household composition
   1. Intact nuclear household
   2. Single-parent household
   3. Remarried family households
   4. Three-generational household
   5. Household including non-nuclear family members

B. Sibling constellation
   1. Birth order
   2. Siblings' gender
   3. Distance in age between siblings
   4. Other factors influencing sibling constellation
      a. Timing of each child's birth in family's history
      b. Child's characteristics
      c. Family's "program" for the child
      d. Parental attitudes and biases regarding sex differences
      e. Child's sibling position in relation to that of parent

C. Unusual family configurations

Category 2: Life Cycle Fit

Category 3: Pattern Repetition Across Generations

A. Patterns of functioning
B. Patterns of relationship
C. Repeated structural patterns

Category 4: Life Events and Family Functioning

A. Coincidences of life events
B. The impact of life changes, transitions, and traumas
C. Anniversary reactions
D. Social, economic, and political events

Category 5: Relational Patterns and Triangles

A. Triangles
B. Parent-child triangles

C. Common couple triangles
D. Divorce and remarried family triangles
E. Triangles in families with foster/adopted children
F. Multigenerational triangles
G. Relationships outside the family

Category 6: Family Balance and Imbalance

A. Family structure
B. Roles
C. Level and style of functioning
D. Resources

FAMILY SYSTEMS EVALUATION

NOTE: YOU MUST INCLUDE EVERY ITEM. IF DATA IS LACKING, STATE PLAN FOR OBTAINING I NFORMATION.

I. DATE OF REPORT

II. IDENTIFYING DATA

III. HISTORY OF REFERRAL

IV. PRESENTING PROBLEM
- Is there conflict about why the family is coming for t reatment
- What does the therapist see as the problem

V. DESCRIPTION OF FAMILY

A. Family as a system in the present:
Projective system, role assignments, communication, triangles, fusions, attempts at differentiationm etc.
Rigidity and flexibility

B. Relationship of Marital Pair:
Include history of marriage and psychosocial hisrory of each spouse

C. Parent-child relationships:
Include psychosocial history of each child or adolescent

D. Sibling Relationships:
Include history

E. Relationship to extended family network

F. Relationship with Society

G. Significant medical history

H. Other information not included above

I. Brief summary of family

VI. RELATIONSHIP TO THERAPIST
- How does therapist relate to the family and how does the family react to the therapist's interventions?

VII. PLANS FOR TREATMENT

A. Current goals for family change:
1) Short-term
2) Long Range

B. Methods to be used by therapist

C. Other therapeutic modalities besides family therapy

D. Summary of progress in time since first seen

Recovery Center
Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960-1998
914-348-2070 • 800-922-5535

Consumer::_____ **Referent:** _____

Signature: _____ Signature: _____

A. Complete this statement: *Change* is _____
_____
_____

B. Presenting Problems: Circle the areas on the list which you think may be a problem for you.

Trouble at school/work	Problems with friends	Suicidal thoughts
Legal issues	How I eat	Lack of Confidence
Poor communication skills	Abuse of alcohol	Too much energy
Trouble at home	Can't concentrate	Not liking myself
Acting with out thinking	Running away	Feeling restless
Missing a Family member	Abuse of drugs	Hurting myself
Trouble following rules	Bad moods	The way I look
Problems with authority	Getting angry	Stealing
Health Problems	Feeling all alone	Feeling afraid
Losing Friends or family	Problems sleeping	Sex problems
Other_____		

1) Looking over these things you have circled, which three problems are most important for you?

_____ _____ _____

2) Write a goal statement of what ***changes*** you want to make and what you want to accomplish in <u>treatment.</u>

3) My referent/program believes my problems are:
   A)
   B)
   C)

C. Beliefs -

1. What are your *<u>beliefs</u>* about Recovery?

2) What are your ***beliefs*** about addiction and mental illness?

3) What are your ***beliefs*** about the medical problems related to addition and mental illness?

4) What are your families ***beliefs*** about addiction, mental illness, treatment and recovery?

5) How are your family's ***beliefs*** similar/different from your own beliefs?

6) How can the program help you *change*?

7) How can we help you with your commitment to *change*?

8) What three *steps* will you taking today.
   A)
   B)
   C)

9) What are three of your *strengths/assets?*

   A)
   B)
   C)

10) What do you *value* about yourself as a women/man?

11) What do you want to learn about yourself, your addiction and your recovery?

12) What do you want to teach us about yourself, your addiction and your recovery?

13) Where do you want to go from here? What are your goals? objectives?

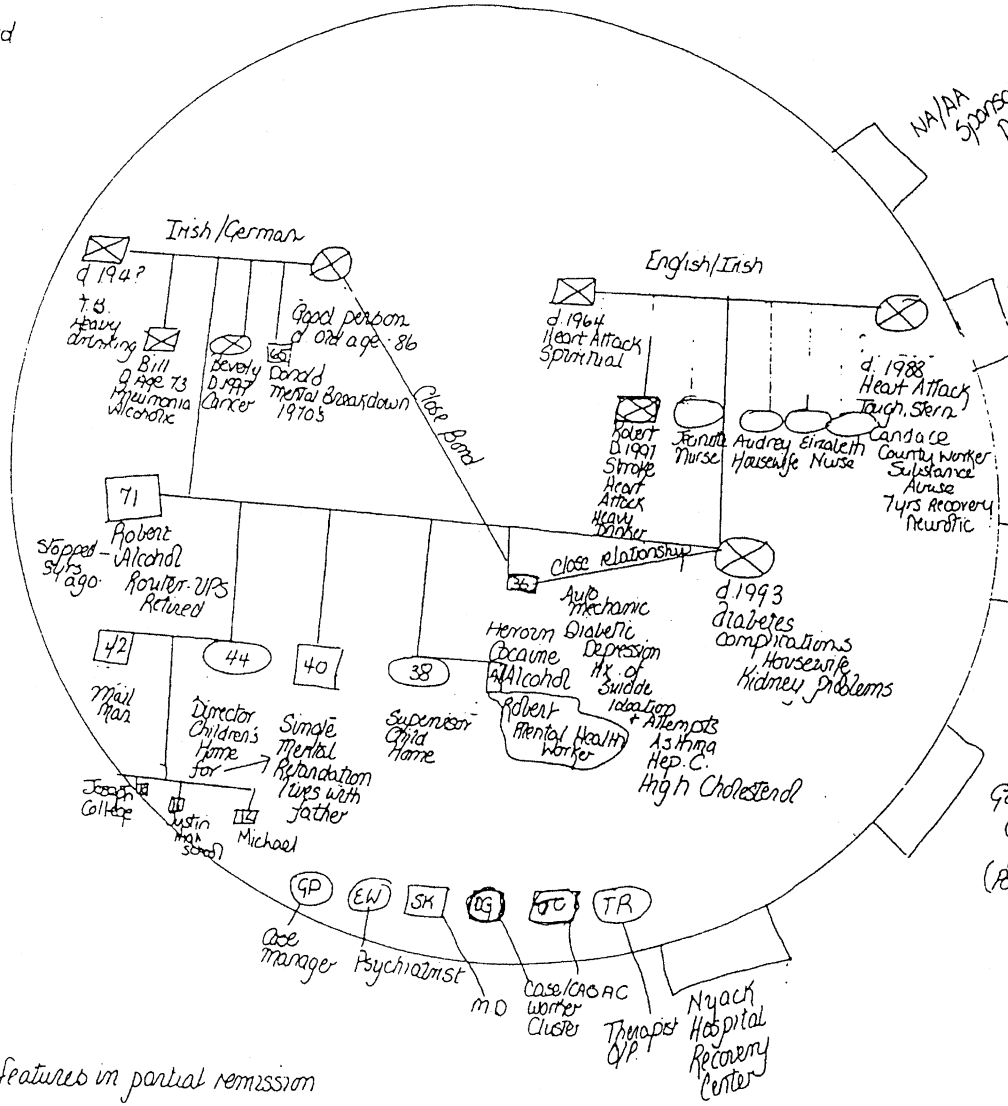
14) How can we help you accomplish your goals?

Changes Patient Wants to make
1. Get reconnected with 12 Step
2. Learn to take Suggestions
3. Able to ask for help when needed

Changes Case Manager Sees Need for
- Reconnect with 12 Step
- Identify feelings
- Learn communication Skills
- Learn Healthy Coping Skills
- Learn Stress Management Skills
- Begin to resolve feelings over death of mother
- Address procrastination

Graduated High School
Mercedez Benz · Auto Mechanic

Multiple Treatments
2 Suicide Attempts 84 + 96
Schizo-Affective by History
Depression-Major with Psychotic features in partial remission



Recovery Center
Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960-1998
914-348-2070 • 800-922-5535

Consumer Beliefs Questionnaire

Beliefs are what you believe in your heart of hearts

1. What are your beliefs about addiction/chemical dependency?

2. What are your beliefs about mental illness?

3. What are your family's beliefs about addiction/chemical dependency/mental illness? Are their beliefs the same or different from yours? Explain:

4. What were your beliefs about addiction/mental illness while you were using?

5. How have your beliefs about addiction/mental illness changed since entering treatment?

6. What changes in your beliefs about addiction/mental illness do you want to make?

7. What changes in your beliefs and behavior are you willing to make in order to be a survivor?

Beliefs Questionnaire -Page 2

8. What are your beliefs about recovery?

9. In order to make a 100% commitment to your recovery, what changes in your beliefs about your addiction/mental illness, and recovery do you need or want to make?

10. What are your strengths? List.

    a.

    b.

    c.

    d.

Beliefs and Healing Group: Weekly Beliefs, Resiliency and Healing group for all rehabilitation patients. In this group, patients and staff join together in a dialogue on the meaning of illness in their life, their beliefs about the illness of chemical dependency, and other chronic illnesses. The family context, i.e. Values, Beliefs which serve to guide our decisions and behaviors, which can either constrict or facilitate healing. We believe spirituality is vital in the recovery process; group members share their personal feelings, beliefs, pain and spirituality in an effort to explore this component of the healing process. The issue of resiliency and coping skills in managing chronic illness is emphasized and the members are guided to identify their strengths and those of their peers. The group is assigned journal tasks where they observe themselves and their peers, staff for strengths and qualities of resilience. Multimedia techniques are incorporated i.e. videos, audios, music addressing survival and recovery.

Recovery Center
Nyack Hospital

Faculty/ Provider Fellowship from the Addiction Technology Transfer Center (ATTC) funded through The Center for Substance Abuse Treatment and directed by the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS)

Special Professional Grand Rounds

www.nyackhospital.org

July 9, 1999

Krutz Auditorium

An Ecosystemic Addiction and Mental Illness Treatment Model for Multi-Diagnosed Consumers, which addresses Patient/Family, Agency, Referent, Caregiver, and System Issues

The use of an ecosystemic family systems model as a way to understand and treat clients suffering with addiction and multiple problems bridges core medical, psychological, social work, nursing, and recovery knowledge and practice realities. Treatment for multi-diagnosed patients benefits from a widened ecological perspective which takes into account contextual systems, subsystems, and all the various professionals and people involved with the consumer and their family.

8:30 a.m. - 9:00 a.m.	Registration and Continental Breakfast
9:00 a.m.	Welcome ***Meigs Ross***, Chaplin
9 00 a.m. - 9:45 a.m.	**"The Ecological/Ecosystemic Model: Principles and Practices"** ***Richard H. Gelb, M.A.***, Director, Recovery Center
9:45 a.m. - 10:30 a.m.	**"Referent, Patient/Family, and Program Context"** ***Annette Bonets, B.S.***, Admissions Coordinator, Recovery Center
10:30 a.m. - 10:45 a.m.	Break
10:45 a.m. - 11:30 a.m.	**"Treatment Application"** ***Barbara Tabala*, CASAC**, Clinical Supervisor, Recovery Center ***Gillian Pines***, Case Manager, Recovery Center
11:30 a.m. - 12:00 noon	**Question and Feedback**

Registration Form

914-348-2070
(fax) 914-358-9085

PROFESSIONAL GRAND ROUNDS — SUMMER SERIES

Name:_____ Degree (s)_____

Preferred Mailing Address: [ ] Business [ ] Home

Work Phone ( ) _____ Home Phone ( )_____

Address: _____ Apt.:_____

City: _____ State:_____ Zip:_____

Organization/Agency:_____ Position:_____

Please detach and return to the Recovery Center by July 1, 1999

Return to: The Recovery Center of Nyack Hospital
160 N. Midland Avenue
Nyack, NY 10960

Program Development and Staff Training

A format for assessment, analysis and evaluation of the systemic and contextual issues which considers the patient/client and family's psychosocial, medical, addiction and psychiatric needs will be presented in a theoretical format. This ecological assessment will include the referent's needs and expectations, services required, treatment planning, staff roles and function and delivery of an integration program of addiction, mental illness, medical and psychosocial services to meet consumer/patient needs. All of the above requirements will be presented with clinical applications of genograms, ecomaps, family assessment forms, context checklists and analysis of change vs. status quo dilemmas.

Faculty and Provider Fellowship Program

Sponsored by

New York State Addiction Technology Transfer Center (ATTC)
Funded through
The Center for Substance Abuse Treatment
and directed by
The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS)

Richard H. Gelb, MA
Director
Addiction Services
Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960
Tel: 914 348-2073
Fax: 914 358-9085

Nyack Hospital

NYACK HOSPITAL

ADDICTION SERVICES

ECOLOGICAL ADDICTION AND MENTAL ILLNESS TREATMENT MODEL

"COURAGE TO CHANGE"

Recovery Center
160 No. Midland Ave
Nyack, New York
10960

Center for Change
Two Blue Hill Plaza
Pearl River, New York
10965

Dual Diagnosis Program Outlines

- Psychometric and clinical assessment at time of admission to establish a differential psychiatric diagnosis and identify critical psychosocial factors impacting on the dually diagnosed individual.
- Assignment to the individual and/or group psychotherapy programs within the Recovery Center's rehabilitation track.
- Where indicated further psychological, psychosocial and cognitive factors impacting on the patient and which would likely prove essential for effective treatment planning.
- Patients in the psychotherapy program are assigned to specific psychological treatment modalities based on the initial and ongoing assessment of their clinical-psychiatric needs. These treatment modalities include:
    - Referral for psychotropic medication
    - Supportive individual psychotherapy
    - Cognitive-behavior individual psychotherapy
    - Biofeedback relaxation/stress management training
    - Neurobiofeedback therapy
    - Group psychotherapy
- Each patient's particular psychological treatment program is monitored and reviewed in weekly interdisciplinary psychiatric/psychological services rounds.
- Each patient's treatment is tracked in detail in weekly supervision of the program therapists with the program's consulting psychologist.
- Pre and post psychometric profiles are utilized as basic treatment outcome measures.

Please contact us for additional information on the dual disorders services to discuss a patient, to scheduled an admission assessment or to arrange for a meeting with your staff.

Admissions
(914) 348-2073
Fax
(914) 358-9085

Directions
From NYS Thruway South:

Exit 11 to traffic light. Left onto Route 59 east to next traffic light. Left onto Route 9W North. Nyack Hospital approximately 2 blocks on rights.

From NYS Thruway North:

Exit 11. Through stop sign to traffic light. Left onto Route 9W north. Nyack Hospital is approximately 2 blocks on right.

Bus - Red/Tan from GW Bridge to Nyack, New York Train - MetroNorth from Grand Central Station to Tarrytown, New York

Nyack Hospital

NYACK HOSPITAL

ADDICTION SERVICES

RECOVERY CENTER

INTEGRATED DUAL DIAGNOSIS TREATMENT

"COURAGE TO CHANGE"

160 North Midland Avenue
Nyack, New York 10960

Working Draft:

Evaluation of an Ecosystem Module and a Pilot Study of Utilization of Training

August 11, 1999

Cheryl E. Whitley, CSWR, Ph.D.

Richard Gelb, M.A.

Sherry Dingman, Ph.D.

Tamiko Bell, B.A.

Working draft:

In order for the best available knowledge and skills to be utilized in addiction treatment settings, practitioners from all relevant disciplines are educated and trained. While we know a good deal about the effectiveness of treatment, we know less about the efficacy of education and training. In this pilot study, we have undertaken a two fold task. First, we have evaluated the immediate impact of the training module, Ecosystems Approach to Treatment of the Addicted Client. Secondly, we have begun to identify a set of factors that are potentially predictive of utilization of the ecosystems approach to treatment. We propose to develop a model that will be useful for administrators and others who may use training and education to prepare students or staff for the field of addictions treatment. Mutual consideration of utilization of training by administration and staff has the potential to increase dialogue across disciplines and among those with differing responsibilities. This can increase effectiveness of training, use of funds, service delivery, staff satisfaction, and ultimately treatment.

In the field of addictions treatment, a number of perspectives coexist. The self-help model of Alcoholics Anonymous, mental health perspectives, public health interests, family systems approaches, and various medical models often compete within the same facility. A system needs to be devised to bring to bear on the problems of the client/patient the most helpful knowledge and skills that arise from each paradigm. In addition, the world view of the client, his significant others, family and friends, other treatment providers including the referent, are important for assessment and treatment planning. The ecosystems paradigm can provide a

framework in which each perspective is valued.

In order for the ecosystems model to be considered and implemented within treatment settings, both education and training are needed. Education is characterized by "examination of theoretical underpinnings" while training "is essentially about the transfer and acquisition of skills (Roche, 1998, p. 87)." Agency staff, faced with daily demands of treating clients, are more likely to favor skill training. Staff without degrees may be more accustomed to skill training as well. Those whose philosophy is grounded in the self help movement of Alcoholics Anonymous may view as pernicious philosophical discussions apart from the obviously tried and reliable AA model.

The ecosystems model represents a different framework or paradigm from which to view treatment of addicted persons. It is an incorporating model that treats as significant the perspectives of all persons, groups, agencies and other systems related to the identified patient. The purpose of looking at all parts of the client system is to identify strengths and curtail liabilities, to capture the hopes of those involved, and to bring to awareness beliefs and consequent behaviors that are impacting recovery. Ideally, the views of all members of the wider or eco system are treated as important and worthy of respect.

Method:

Evaluation of the ecosystem training module

In order to evaluate the effectiveness of the ecosystem module developed under this faculty provider grant from the Addictions Technology Transfer Center, two pilot questionnaires have been developed, approved by the Marist College Institutional Review Board, and field

tested. The first questionnaire contained factual questions related to the "ecological world view," the "most important system," the goal of assessment, and change. Results of asking factual questions were not satisfactory. Respondents often skipped questions. The questions did not capture the intent of the training. After the piloting of the questionnaire at a county task force for the mentally ill chemically addicted the questionnaire was rewritten.

In order to develop the second questionnaire, the director of a hospital inpatient treatment facility and a staff member directly involved in implementing the ecosystems perspective at the hospital met with the two researchers involved in development of the evaluation. The goals of the training were specified. Participants were (a) to understand the ecosystems perspective; (b) to understand the importance of the client's beliefs about recovery; (c) to understand the role of the referent's reasons for referring the client; (d) to understand the effect on client recovery of the care-giver's beliefs about recovery; (e) to understand the effect of beliefs about recovery held by members of the client's social network and (f) to understand the importance of valuing every perspective in the system.

Five questions were devised in which the training participants were asked to rank elements of the intake and admission process. Rank order testing was chosen over factual information, because it is more subtle and may capture change of perception. The aim was to determine whether the information affected the participants' perceptions of the relative importance of factors highlighted in the training rather than whether participants could repeat the information conveyed. Participants were asked to rank in order of importance aspects of specific treatment related activities and which factors will bring positively influence recovery. Activities

included: gathering initial information; ways to collect information for intake; choosing sources of information for the admission process; and choosing sources of information for treatment planning. Participants also ranked predictors of treatment outcome. These parts of the treatment process were chosen, because the present training module addresses the earliest phases of treatment. The module is being developed incrementally to address each part of the treatment process. These questions were imbedded within pre and post tests.

These pre and post tests were administered at a training on the ecosystems model held at an upstate New York Hospital with a known addictions treatment unit. Of the thirty-five participants, eighteen took both the pre and post tests. Analysis of the results was carried out with the support of the Statistical Package for Social Sciences (SPSS).

Utilization of training:

The pilot study to identify factors that influence utilization of training began with focus groups conducted with staff at an upstate New York hospital inpatient and out patient unit in March, 1999. Without the administrator present, staff who had gathered to conduct daily rounds for case evaluation responded orally to a set of questions designed to elicit from them factors that would influence their use of training. This session was audio taped with participants' permission. The researcher also took extensive notes, so that a verbatim account could be constructed. The following questions were asked: What would cause you to use new training information? What would prevent you from using new training information? What would cause you to use knowledge about families of patients/clients? What gets in the way of using what you know about families of patients/clients? The focus group process was repeated with the

outpatient staff. The audio tapes failed; therefore the hand written notes were used. Those notes were transcribed and content analyzed. A set of variables were operationalized as questions that were included in the evaluation questionnaire discussed above.

In May, 1999, the questionnaire with utilization related items was piloted at a county meeting of task force members concerned with treatment of mentally Ill chemically addicted.. Following the pilot run, the questionnaire items related to utilization were revised, and responses were reordered to avoid bias. The questionnaire was then administered as a pre and post test at a training session on the ecosystems model held at an upstate New York hospital in July, 1999. Eighteen of the thirty-five attenders completed the pre and post tests. The intent was to determine if ecosystem related activities had been carried out to a greater extent following the training than at the time of the training. The intent was also to determine whether increased ecosystem related behaviors were related to specific predictive factors identified through the focus group process and presented as questions within the questionnaire. When more pre and post tests are completed at later training sessions, these will be combined with the first set of questionnaires to form a larger data base. Analysis of the utilization factors will be possible with a larger data pool.

Participants at the hospital based training session were also given genogram outlines to complete and were told that staff would be available to give feedback on construction of the genogram. A stamped return envelop was included. This was an effort to establish predictive validity.

The evaluation hypothesis

The evaluation of the ecosystem training module was conducted to test the hypothesis that persons trained in the ecosystem module are more likely to perceive as significant for patient recovery beliefs held by the client and members of the client's eco-system concerning recovery from addiction to alcohol and other drugs. Significant system participants include the patient him or herself, care-givers, patient family members, and referents. Use of family history as depicted in genograms and client systems as portrayed in eco-system maps were chosen as indicators of perception of an ecosystem perspective as valuable.

Findings:

Evaluation of the ecosystem training module

Thirty-five participants took part in a training session that provided both education and skills training on the ecosystems approach to the admissions, intake, and treatment planning process for addicted persons. Of the nineteen persons who took the pre and post test, ten were outpatient staff, two were inpatient staff and seven were other. Other included clergy and residential service providers. Six were direct care staff, seven clinical staff, three administrative staff, one clerical and two gave "other" as their role. Three attenders held addictions and substance abuse certification. Eight had bachelor's level education, and eight had masters degrees. Social work was the predominant profession. Eleven were social workers, six addictions counselors, and two were in nursing.

To test the hypothesis that persons trained in the ecosystem module are more likely to perceive as significant for patient recovery beliefs held by members of the client's eco-system concerning recovery from addiction to alcohol and other drugs, participants were asked to rank

order lists of factors related to five aspects of treatment and recovery. The questions were as follows: *Rank order* the importance for the client/patient's recovery of gathering the following **information** beginning with number 1 for most important **information** and **numbering** all items in the boxes provided. *Rank order* the following predictors of treatment outcome from most important to least important. *Rank order* the following **ways** to collect information for intake from the most effective to the least effective. *Rank order* the usefulness of the following sources of information for the admission process. *Rank order* the usefulness of the following sources of information for treatment planning. (See attached questionnaires for the lists of responses.)

Ranking the following items closer to first choice in importance is deemed by the researchers to indicate perception that beliefs held by the client and members of the client's eco-system concerning recovery from addiction to alcohol and other drugs are significant for patient recovery: patient's beliefs about AOD recovery, referents' goals, caregivers' beliefs about AOD recovery, family's beliefs about AOD recovery, client's/patient's beliefs about alcohol and other drugs, family's motives for wanting individual in treatment, client/patient's motives for entering treatment, (use of) a genogram or family history, (use of) referent's evaluation of the patient, client's/patient's signed release to involve referent, (use of) genogram, (use of) eco-map, client's/patient's signed release to involve family. When ranking on the factors above were compared on the pre and post questionnaires, subjects were found to have ranked these indicators significantly higher on the post test, $t\ (df = 4) = 3.53$, $p = .024$.

Utilization:

When pre and post test responses to utilization factors were compared, no significant

difference was found. This was not surprising. When more data is collected, follow up calls will be made to training participants to determine whether participants have increased ecosystem focused behaviors. These findings will be correlated with factors that may be predictive of use of training.

Conclusions:

Training and education can result in a refocusing of attention of participants to include broader array of system factors when choosing what to consider in admission and treatment planning processes. Results of this preliminary evaluation indicate that the training resulted in a significant shift in perception among participants. This finding will likely be strengthened when more data is collected at later training sessions. More research is needed to determine the effects of changed perceptions on approaches to treatment programming.

Whether training will be utilized is a complex question. Numerous factors interact to facilitate or hinder implementation of new knowledge. This study is the beginning of a process to identify the factors that are most significant to utilization. More training participants must be willing to complete pre and post tests and to respond to follow up inquiry in order to form a database to analyze the factors. Qualitative studies of facilities will also help isolate the structural factors that support use of training. Staff members have a clear sense of those factors that influence their use of training. Agencies will benefit from open dialogue among staff about supports needed to bring about enactment of new training.

References:

Dewit, D.J., Timney, C.B., Silverman, G. & Stevens-Lavigne, A. (1996). Process evaluation of a comprehensive drug education training package. Journal of Alcohol and Drug Education, 4(3), 102-122.

Galanter, M., Keller, D.S., & Dermatis, H. (1997). Network therapy for addiction: Assessment of the clinical outcome of training. American Journal of Drug and Alcohol Abuse, 23(3), 355-367.

Garcia, B. (1998). Professional development of AODA practice with Latinos: The utility of supervision, in-service training, and consultation. Alcoholism Treatment Quarterly, 16(½), 85-108.

Gregoire, T.K. (1994). Assessing the benefits and increasing the utility of addiction training for public child welfare workers: A pilot study. Child Welfare, 73(1), 69-81.

Jones, D.J. & Bowler, S. (1997). The link between a participants' perception of training and subsequent levels of application. Journal of Alcohol and Drug Education, 42(2), 53-68.

Kirk, C. & Amaraneth, K.R. (1998). Staffing issues in work with women at risk for and in recovery from substance abuse. Women's Health Issues, 8(4), 261-266.

Long, C.G. & Hollin, C.R. (1998). How do you know if your treatment of problem drinking is successful?, 5(3), 167-176.

Martin, G.W., Herie, M.A., Turner, B.J., & Cunningham, J.A. (1998). A social marketing model for disseminating research-based treatments to addictions treatment providers. Addiction,

93(11), 1703-1715.

Ogborne, A.C., Wild, T.C., Braun, K., & Newton-Taylor, B. (1998). Measuring treatment process beliefs among staff of specialized addiction services. Journal of Substance Abuse, 15(4), 301-312.

(1997) The role of family and significant others in the engagement and retention of drug-dependent individuals in Onken, L.S., Blaine, J.D., & Boren, J.J. (eds.) Beyond the therapeutic alliance: Keeping the drug dependent individual in treatment. (NIDA Research Monograph 165 pp. 157-180) Rockville, Md.: NIDA,

Roche, A.M. (1998). Alcohol and drug education and training: A review of key issues. Drugs: Education, Prevention, and Policy, 5(1), 85-99.

Taleff, M.J. & Babcock, M. (1998). Hidden themes: Dominant discourses in the alcohol and other drug fields. International Journal of Drug Policy, 9(1), 33-45.

Appendix A: Focus group outcome: Inpatient Staff

In-patient staff discussion of utilization of training

Staff included medical personnel, social workers, psychologists, case-managers

March 25, 1999

The purpose of the following discussion was to discover under what conditions staff say they are more likely to make use of new clinical training. This session was audio-taped with the intent of providing a transcript. Unfortunately, the tape was exposed to some sort of magnetic field and erased. The following discussion is taken from notes; therefore it may be incomplete or inaccurate. Those who participated in the discussion are encouraged to correct the discussion and send changes to Cheryl Whitley at Marist College via email at JZHU@MARISTB.MARIST.EDU or to call 914-575-3000 ext. 2982.

The following are the key questions being asked. Feel free to add to this discussion by responding to these questions.:

What would cause you to use new training information?

What would prevent you from using new training information?

What would cause you to use knowledge about families of patients/clients?

What gets in the way of using what you know about families of patients/clients?

Question: What would cause you to use new training information?

If it is valuable to help the patient, if it can be applied

How does it fit my lifestyle, my delivery? Do I like it, believe in it? If I have different patients (with different needs), I'll look for (the information that fits).

New information is a risk. There may be a perception among my peers that I'm better or different than they are.

Medically, a new treatment could be "off label", different from one's professional community. Does the new information help the clinician grow, to stay abreast of (treatment in the profession)? (On the other hand) new information can be negative. One learns it, and later the information is no good. One ends up looking foolish. It's not done that way (any more). For example, TIQs. There's no such thing. It's out of date.

I have to believe in it in order to present it.

I want to present new information so it's not intimidating to the patient.

(It's a problem) to appear more knowledgeable than my peers. They may feel intimidated.

Question: What would prevent you from using new training information?

Not fully understanding (the perspective, techniques).

When follow up information is not enough

Follow up needs to be structured, organized. Follow up needs to be tailored so that I can run it

(my efforts to apply the knowledge and skill) by people who know what you're doing.

When the administration is against it.

The administration must be more open. Have a paradigm shift. There is liability. The administration must pay for it. More than one person must be trained. There must be no negative evaluations (coming out of trying it) if it doesn't work out. There must be *enough* training! For example, grand rounds is a positive thing here.

Question: What would cause you to use knowledge about families of patients/clients?

We need more training specific to families.

For example, we need critiquing of what you are doing. There must be time and money.

In terms of families, people come from families. It's a contributing factor. (It's important.)

Question: What are the blocks to using what you know about families of patients?

Families don't want to engage.

We need more training on *engaging families*! For example, what if family members are using (AOD), do we treat them?

Then there's the shame and guilt of the family.

Staff are busy. There are time factors. (Seeing the family in in-patient) means preparing the patient for the family session,(doing the family session), dealing with the after-math with the patient. It's difficult and may be clinically risky. We open this pain, then what?! Will there be referral for the family?

We need an outcome study to determine if family work is actually effective.

We need more staff to do family work.

Family work is not cost effective.

Outpatient (facilities) could have family treatment built in. In the in-patient unit, it's a flat rate. It's not easy to build in.

With families, it can open up "a can of worms" and can create more problems. Outpatient is a better place to work on families or maybe private practice, where there is time. Here in 28 days, we see the family once.

The HMO's and length of stay impacts what we do. With 3-5 days, it's not a physical possibility.

In addition, to do family work, we need to understand people's distinct cultures.

Appendix B: Focus Group: Out-patient

Out-patient staff discussion of utilization of training

March 25, 1999

The purpose of the following discussion was to discover under what conditions staff say they are more likely to make use of new clinical training. This session was audio-taped with the intent of providing a transcript. Unfortunately, the tape was exposed to some sort of magnetic field and erased. The following discussion is taken from notes; therefore it may be incomplete or inaccurate. Those who participated in the discussion are encouraged to correct the discussion and send changes to Cheryl Whitley at Marist College via email at JZHU@MARISTB.MARIST.EDU or to call 914-575-3000 ext. 2982.

The following are the key questions being asked. Feel free to add to this discussion by responding to these questions.:

What would cause you to use new training information?

What would prevent you from using new training information?

What would cause you to use knowledge about families of patients/clients?

What gets in the way of using what you know about families of patients/clients?

Question: What would cause you to use new training information?

(There may be) a certain type of population. (Let's say) working, discussing, planning-it doesn't work. Time brings about changes in the family dynamics, the impact on the family.

If I understood, have comfort with the why and how, it helps. Then I would go ahead and experiment (with using knowledge).

Learning as a team works. We share what works and what flops. (We share the risk.)

How. I need to know how it works, know it works. I need to be confident that it works.

Question: What would prevent you from using new training information?

Lack of understanding it. Not clear. Then I'm reluctant.

Not jumping in right away and trying it. Then I forget it. I need an opportunity to start.

The length of it. It takes time. How much of it would we have to do?

Whoever presented it. They convinced me it would be effective. There is credibility to it (and to the presenter).

Having rapport with the client. (We have a working relationship that is sound and will tolerate trying something different.) We should try something.

A conducive environment. Some agencies (in the past) brought presenters about the family, but the agencies had no component (in the programs) to work with families.

The administration must provide support by (a) evaluating how it's going (b) being involved (c) reinforcing the training (with action) (d) bring someone in to provide support (ongoing)

One word: TIME. Got to have time to do it. Something is adding on, so something is crowded. Who will do it? When?

There must be sufficient time to do the training and practice *before use* with clients.

Question: What would cause you to use knowledge about families of patients/clients?

Feeling stuck. Taking a history and seeing certain traits running through the family, you would want to treat individuals within the family and also treat the family and the patient. For example-help stabilize the patient with some mental condition and then see that in the family others have a similar condition

Trying new things keeps me fresh.

Question: What are the blocks to using what you know about families of patients?

TIME

Transference. Issues, my own base of issues.

Lack of education and resistance of the family members. A tendency (of the family) to focus on the patient as the problem.

- Not having a clear understand that the family is different from the identified patient and needs a different way of handling it
- The agency: Must provide support in getting families in, demonstrate how to get the families in and GET the families in.
- Having someone who only does family work. (would help)
- Train everybody.
- Financial issues: For example, we could see families in groups, but scheduling families and

individuals cuts into (existing) groups

- How does the administration see doing family work?
- We run into problems. Insurance won't cover family work. Companies find loop holes so they won't have to pay; therefore the family won't commit when they have to pay for it. Charging high rates for family work to the family is an excuse.
- The majority of focus is on the person. We want to create and use assessment tools for family work, but we don't have the time. We need training, as assessment is geared to the individual.
- We don't take time to do supervision on the family.

It takes investment of time and money. It won't happen "just because". Basically it equals manpower/people power

It may not be one person if one person didn't curtail focus on the family and case loads were cut in half, and we gave each person time to do the work, and ALL case-managers and clinicians were equipped with knowledge then it would work.

Paper work is choking out our TIME!

Appendix C: Informed consent

Eco-system approach to service delivery: Informed Consent

Good morning. Instead of the usual course feedback process, we are attempting to find out if you consider the training itself useful or effective. The Recovery Center and the Marist College Social Work Program have received a grant from the Addiction Technology Transfer Center to evaluate this training. Your participation contributes to understanding of the effectiveness and utilization of training. This study does not test whether you know the material. This study was reviewed and accepted by the Marist College Institutional Review Board for protection of human subjects of research.

Completion of the pre and post questionnaires is voluntary. You are under no obligation to complete them. You may skip questions. Your name will not be connected with your responses. Results of the study will be available to you at your request. You may stop at any time.

The collected questionnaires will be sealed and sent to the investigators at Marist College. Only the Marist researchers, Cheryl Whitley, CSWR, PhD, Sherry Dingman, PhD, and Tamiko Bell, BS, will have access to the completed questionnaires.

If you sign the follow up call sheet, the investigators, but not the presenters, will know your responses.

This questionnaire and the workshop were developed with support from a grant from the Addiction Technology Transfer Center. If you have questions about the content of the presentation or ATTC, you may contact Richard Gelb, Director, Nyack Hospital Recovery Center, 914-348-2088. For questions about ATTC and the questionnaire, you may contact Cheryl Whitley, Assistant Professor, Marist College Social Work Program at 914-575-3000 extension 2982 or CHERYL.WHITLEY@MARIST.EDU.

PLEASE KEEP THIS FORM FOR YOUR FUTURE REFERENCE.

Appendix D: Pre-test
Please complete before the presentation today.

Place an X in the appropriate box

My discipline is:

_ Social Work _ Addiction Counseling _ Nursing _ Medicine _ Psychology _ Other: _____

My level of education is:

_ Certificate _ BA/BS _ MA/MSW _ PhD/PsyD/MD Other: _____

My primary work role is:

_ Direct Care _ Clinical Staff _ Administrative _ Clerical _ Other: _____

The program in which I work is:

_____ Inpatient _ Outpatient _ Other, please specify type _____

In the past two weeks, how many genograms of clients'/patients' families have you written?

_ None _ One _ Two or more: Please specify _____

.How many eco-maps of the clients'/patients' social networks have you drawn in the past two weeks?

_ None _ One _ Two or more: Please specify _____

Rank order the importance for the client/patient's recovery of gathering the following **information** beginning with number 1 for most important **information** and **numbering** all items in the boxes provided:

_ Agency's mission
_ Benefits
_ Patient's medical history
_ Patient's beliefs about AOD recovery
_ Referent's goals
_ Caregivers' beliefs about AOD recovery
_ Type of referent agency
_ Patient's AOD treatment history
_ Patient's current medical status
_ Family's beliefs about AOD recovery
_ Patient's psychiatric history
_ Patient's mental status
_ Patient's legal history
_ Patient's faith experience
_ Patient's social supports
_ Other: please specify_____

Rank order the following predictors of treatment outcome from most important to least important.

_ Caregiver's skill
_ Client/patient's beliefs about alcohol and other drugs
_ Referent's reasons for referral
_ Agency's program

_ Family's motives for wanting individual in treatment

_ Client/patient's motives for entering treatment

_ Other, please specify _____

Rank order the following **ways** to collect information for intake from the most effective to the least effective.

_ A telephone intake form

_ A patient problem list

_ A genogram or family history

_ Referent's evaluation of the patient

_ Mental status examination

_ other, please specify_____

Rank order the usefulness of the following sources of information for the admission process:

_ Psychological assessment

_ Medical/nursing assessment

_ Client's/patient's signed release to involve referent

_ Genogram

_ AOD basic clinical assessment

_ Verification of benefits

_ Psychiatric assessment

_ Ecomap

_ Client's/patient's signed release to involve family

_ other, please specify_____

Rank order the usefulness of the following sources of information for treatment planning:

_ Client's/Patient's problem list

_ Nursing/medical assessment

_ AOD basic clinical assessment

_ Telephone intake assessment

_ Genogram

_ Psychiatric assessment

_ Caregiver's practice wisdom

_ Eco-map

_ Mental status examination

_ Referent's evaluation of the client/patient

_ Psychological assessment

_ Other, please specify_____

For the following items, place an X in the box above your response:

The information being presented in this training will help me do my job.

_ Strongly Disagree _ Disagree _ Somewhat Disagree _ Somewhat Agree _ Agree _ Strongly Agree

This information is helpful to my patients/clients.

_ Strongly Agree _ Agree _ Somewhat Agree _ Somewhat Disagree _ Disagree _ Strongly Disagree

The eco-system model is useful for working with my patients/clients.

_ Strongly Disagree _ Disagree _ Somewhat Disagree _ Somewhat Agree _ Agree _ Strongly Agree

My patients/clients are comfortable using an eco-system approach.

_ _ _ _ _ _

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

An eco-system approach fits the way my agency operates.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I have opportunities to use the eco-system approach now.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

The eco-system approach fits my style of working with clients/patients.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

My fellow employees will appreciate my using the eco-system approach with clients.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I understand the eco-system approach.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

There are people at my agency who use an eco-system approach.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

There are people at my agency who are qualified to use the eco-system approach with clients.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I am personally motivated to learn to use an ecological approach to working with my clients/patients.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I use an eco-system approach to the intake process.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I use an eco-system approach to treatment planning.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I use an eco-system approach to treatment.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I use an eco-system approach to discharge planning.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

The administration at my agency supports using an ecological approach to treatment planning

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

There are people at my agency who will spend time helping me use the eco-system approach.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I am confident that this presenter can help me learn to use an ecological approach.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

Appendix E: Post-test

Please complete after the presentation today.
Place an X in the appropriate box:

My discipline is:

Social Work Addiction Counseling Nursing Medicine Psychology Other: _____

My level of education is:

Certificate BA/BS MA/MSW PhD/PsyD/MD Other: _____

My primary work role is:

Direct Care Clinical Staff Administrative Clerical Other: _____

The program in which I work is:

Inpatient Outpatient Other, please specify type _____

In the past two weeks, how many genograms of clients'/patients' families have you written?

None One Two or more: Please specify _____

How many eco-maps of the clients'/patients' social networks have you drawn in the past two weeks?

None One Two or more: Please specify _____

Rank order the importance for the client/patient's recovery of gathering the following **information** beginning with number 1 for most important **information** and **numbering** all items in the boxes provided:

_ Agency's mission
_ Benefits
_ Patient's medical history
_ Patient's beliefs about AOD recovery
_ Referent's goals
_ Caregivers' beliefs about AOD recovery
_ Type of referent agency
_ Patient's AOD treatment history
_ Patient's current medical status
_ Family's beliefs about AOD recovery
_ Patient's psychiatric history
_ Patient's mental status
_ Patient's legal history
_ Patient's faith experience
_ Patient's social supports
_ Other: please specify_____

Rank order the following predictors of treatment outcome from most important to least important.

_ Caregiver's skill
_ Client/patient's beliefs about alcohol and other drugs
_ Referent's reasons for referral
_ Agency's program

_ Family's motives for wanting individual in treatment

_ Client/patient's motives for entering treatment

_ Other, please specify _____

Rank order the following **ways** to collect information for intake from the most effective to the least effective.

_ A telephone intake form

_ A patient problem list

_ A genogram or family history

_ Referent's evaluation of the patient

_ Mental status examination

_ other, please specify_____

Rank order the usefulness of the following sources of information for the admission process:

_ Psychological assessment

_ Medical/nursing assessment

_ Client's/patient's signed release to involve referent

_ Genogram

_ AOD basic clinical assessment

_ Verification of benefits

_ Psychiatric assessment

_ Ecomap

_ Client's/patient's signed release to involve family

_ other, please specify_____

Rank order the usefulness of the following sources of information for treatment planning:

_ Client's/Patient's problem list

_ Nursing/medical assessment

_ AOD basic clinical assessment

_ Telephone intake assessment

_ Genogram

_ Psychiatric assessment

_ Caregiver's practice wisdom

_ Eco-map

_ Mental status examination

_ Referent's evaluation of the client/patient

_ Psychological assessment

_ Other, please specify_____

For the following items, place an X in the box above your response:

The information being presented in this training will help me do my job.

_ _ _ _ _ _
Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

This information is helpful to my patients/clients.

_ _ _ _ _ _
Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

The eco-system model is useful for working with my patients/clients.

_ _ _ _ _ _
Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

My patients/clients are comfortable using an eco-system approach.

_ _ _ _ _ _

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

An eco-system approach fits the way my agency operates.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I have opportunities to use the eco-system approach now.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

The eco-system approach fits my style of working with clients/patients.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

My fellow employees will appreciate my using the eco-system approach with clients.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I understand the eco-system approach.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

There are people at my agency who use an eco-system approach.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

There are people at my agency who are qualified to use the eco-system approach with clients.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I am personally motivated to learn to use an ecological approach to working with my clients/patients.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I use an eco-system approach to the intake process.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I use an eco-system approach to treatment planning.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

I use an eco-system approach to treatment.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

I use an eco-system approach to discharge planning.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

The administration at my agency supports using an ecological approach to treatment planning

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

There are people at my agency who will spend time helping me use the eco-system approach.

Strongly Agree Agree Somewhat Agree Somewhat Disagree Disagree Strongly Disagree

This presenter helped me learn to use an ecological approach.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

Please add comments about the training:

MARIST

August 12, 1999

Dear Colleagues:

In 1998 and 1999 with the help of grants from the federally funded Addictions Technology Transfer Center (ATTC), I have developed a new course called Addictions and Special Populations. The course was offered last spring for the first time. Students had the opportunity to discover the needs of persons with two and sometimes more conditions, addiction and mental illness, mental impairment or physical challenge. These are the clients our students are likely to serve. The "simple" alcoholic is a person of the past.

The grant support made it possible for the students to visit a treatment program for a day, to participate in rounds, to see the program in action. They heard guest lecturers currently active in developing the integrated treatment programing necessary for doubly and triply challenged clients. Perhaps best of all, they heard from people who identify with these conditions and who could speak from inside the experience.

The Addictions Technology Transfer Center is a resource for all of us. Attached is an article from the latest National Association of Social Workers newspaper. Addiction is the thread of pathology that snakes through the histories of our clients, plagues the children in our classrooms, fills the jails with mentally ill chemically addicted inmates. I encourage you to draw on the assets available to you from ATTC.

ATTC has sent packets for you. More of these are available in my office. Please encourage your students to enroll in one of our addictions related courses in social work or psychology. If I can be of help to you in integrating addiction related knowledge, bibliography, or speakers for your classroom, please let me know. Course outlines for the new course and for Alcohol and the Family are also available. Please call on me.

Sincerely,

Cheryl Whitley

Cheryl Whitley, CSWR, PhD
Assistant Professor Social Work

School of Social & Behavioral Sciences
Marist College
Poughkeepsie, NY
12601-1387
'ephone: 914-575-3960
914-575-3965
)@maristb.marist.edu

Signs of Sobriety, Inc. 865 Lower Ferry Road, Suite B-12, Ewing, New Jersey 08628
TTY: (609) 882-7177 Voice: (609) 882-7677 Fax: (609) 882-6808 TTY: (800) 332-7677
Email Address: SOSnj@Juno.com Web Page: http://members.aol.com/sosnj

Cheryl Whitley
Social Work Program
Marrist College
North Road
378 Dyson Center
Poukeepsie, NY 12601

Dear Ms. Whitley,

Thank you for inviting me to present to your "Addictions and Special Needs" class. I believe the information I presented to your students about deaf people and their community, the substance abuse problems of this population, and their recovery efforts was of value to them. I could see from their responses that these issues gave them a lot to think about and brought up many considerations for them. It was a pleasure to present to such a motivated group.

I want to let you know I was impressed by how you closed your class. The "process report", you asked your students to complete with the "what I am thinking, what I am feeling and what I would do differently if I was involved in this group again", was so rewarding for me to read. They should feel proud of their ability to provide such feedback and awareness of themselves. You have done an excellent job to help prepare them for their future social work experience.

As a social worker that has researched this area, I know little has been done to provide social workers with knowledge about alcoholism or substance abuse. You have taken this one step further and addressed an often-neglected area and neglected populations. I was so impressed with you pioneering work you have done and the gift you have developed for our profession.

Since I have seen you I have had the occasion to present your "Addictions and Special Populations" curriculum to several important groups in the New Jersey area. The curriculum has been well received and I hope that one of these institutions will elect to follow your example.

I am very willing to visit you and your class to present in the future. I want you to know that Signs of Sobriety will be holding a conference in the spring of 2000 on addictions and the deaf. I will send you details on the conference when they are prepared. In closing I wish you the best and look forward to seeing you again.

Respectfully,

Steven Shevlin, MSW
Executive Director

Dutchess

Dutchess County Department of Mental Hygiene

William R. Steinhaus
County Executive

Kenneth M. Glatt, Ph.D.
Commissioner

7 Mansion Street
Poughkeepsie
New York
12601
(914) 486-3700
Fax (914) 486-3727

August 5, 1999

Cheryl Whitley, Ph.D.
Behavioral Sciences Department
Marist College
Poughkeepsie, NY 12601

Dear Cheryl,

I enjoyed being part of the development and implementation of "Addictions and Special Populations", at Marist, Spring, 1999. It is particularly rewarding to know that special populations are not only being acknowledged at long last, but are actually receiving needed attention from the addictions services community.

I believe that the course "Addictions and Special Populations" is worthwhile, comprehensive, and unique. For many students, the course was, and will continue to be, an initial encounter with the notion that addiction is an equal opportunity disease, and that being physically or mentally challenged does not provide immunity from chemical dependence. This may very well be a new concept for many persons, not just for young students, and for this reason, I think that people with more life experience would obtain greater benefits from it. Perhaps the course would be even better received if offered in a graduate level program.

It has been a pleasure working with you and I hope that we will continue to keep in touch and possibly collaborate again in the future.

Sincerely,

Mary Phillips

Mary Genne'-Phillips, M.S., C.A.S.A.C.

Supplement and teaching discourse
Addictions and Special Populations: A three-credit college course
Marist College, Poughkeepsie, NY 12601
Cheryl E. Whitley, CSWR, Ph.D.

Enrollment:

I am writing my experience teaching Addictions and Special Populations, a course created under the auspices of The Addiction Technology Transfer Center, and taught for the first time in the spring term, 1999 at Marist College in Poughkeepsie, NY. On the following page is the course outline that was distributed to the students in late January. Of the 23 enrolled students, 18 students completed the course. Three students never arrived and two left after one session. Seven students were juniors, nine were seniors, and one was a sophomore. All the students were of traditional college age. The students' majors were social work, psychology, criminal justice, and communication. Five students had alcohol or drug-related education or training. The prerequisites for this course include having taken one such course. But in order to have sufficient enrollment, this requirement was waived. Of the 18 students, only one was male, and he was also the lone communication student.

Texts:

The textbooks and readings for the course reflect the fact that more has been published concerning the client with mental illness and addiction than about those suffering mental impairment or physical challenge and addiction. The texts themselves were adequate for the course. The articles provided key discussions that were necessary to grasp the material. As I taught the course and met more people in the field, I found rich materials particularly dealing with the deaf addicted population. Materials are scarce concerning addiction among mentally impaired groups. Those include not only people with limited comprehension, but also persons with brain injury or disease.

Early student response:

Student response to the course was on the whole positive; however their youth and lack of prior formal knowledge of addiction and its effects presented challenges for both teaching and learning. Having prepared for a year to teach the course, I was eager to share what I had learned. Understanding addiction takes time. There are many debates and unanswered questions in the field. I needed to introduce the students to basic concepts before they could be drawn into discussion of emerging issues. The course was set up with a review session to start. That presumed the students' having background in the field. My day one notes say, "Addiction, view and review, testing the waters with students' understanding." That was a wise note. After the students shared their motivations for taking the course, I gave the background of the course itself, its sponsorship, and the hopes for new funding. I talked about basic ideas such as tolerance, progression, physical and psychological effects of alcohol and other drug use, and the effects of addiction in the social environment. This was all new to most of the students. By the third week, all the students had attended an AA meeting. They wrote reaction papers about their AA meeting experience that showed their better understanding of the experience of addiction. Faces of people and their stories helped the students understand and care about what they heard and read.

MARIST COLLEGE
School of Social and Behavioral Sciences

Social Work 392L: 111: Addiction and Special Populations
Spring 1999 Tuesday and Thursday 11:00 A.M.

Cheryl Whitley, CSWR, Ph.D.
Office: Dyson Center 378, Extension 2982, JZHU@MARISTB

COURSE DESCRIPTION: This course was developed under the auspices of the Addiction Technology Transfer Center to provide a grounding for students entering the addiction field where clients served are most likely to suffer from more than one difficulty. Students will explore the struggles of persons with addiction and intellectual impairment of various kinds, mental disturbance, or facing addiction with physical challenge. These various challenges interact with the addictive process, each affecting the other. These interactions and multiple recoveries require specific, integrated attention. One disorder also prompts relapse or difficulty coping with the other; therefore the person coping must have some understanding of a double recovery process in the case of mental disorder and a dual coping process where there is mental impairment or physical challenge. Families are doubly challenged as well to survive and thrive in the face of often-severe stress. Organizational systems including treatment facilities and their staff members experience multiple kinds of stress, financial, structural, emotional, as they attempt to meet the client/consumer needs. Finally, all of us need to work toward understanding and systemic prevention. This course presumes prior knowledge of addiction and its impact on persons within their social environments.

COURSE OBJECTIVES:

As outcomes of participation in this course, the student will

1. Renew and update his/her knowledge of developmental, bio-psychosocial components of addiction: types, indicators, physiology, and psychology.
2. Recognize the potential for and indicators of cross and dual addiction.
3. Understand that clients face not only challenges of addiction, but also multiple challenges including addiction and mental illness, intellectual impairment, physical challenges, and/or criminal or court involvement.
4. Understand how one condition interacts with and exacerbates difficulties arising from other challenges.
5. Begin to get in touch with one's own feelings, attitudes, and issues, which arise in relation to working with persons with addiction and other challenges.
6. Comprehend the importance of recovery in the lives of people with multiple challenges whether mental, intellectual or physical.

7. Know how to conduct a bio-psychosocial assessment of psychiatric symptoms, substance use history, and other relevant conditions and their enabling systems.
8. Assess strengths and resources within and around the client and the system.
9. Consider the nature of mental illness and the factors, which affect human mental function.
10. Become familiar with the Diagnostic and Statistical Manual (DSM-IV).
11. Be aware of the symptoms associated with of DSM-IV Axis I mental illnesses and the possible relationship between substance abuse and these psychiatric disorders.
12. Be aware of symptoms associated with mood and personality disorders and the relationship between these disorders and possible substance abuse.
13. Recognize the origins and indicators of trauma, its connections to substance abuse and its implications for treatment and recovery.
14. Become familiar with treatment elements usually included in the recovery process for people suffering both addiction and a mental disorder: 12 step programs, family work, collateral work, pharmacology, and ongoing supportive case management.
15. Understand the difference between "street drugs" and medications and the implications for treatment.
16. Have a basic comprehension of developments in the pharmacological treatment of mental illness and addiction and their implications for attaining and maintaining recovery.
17. Comprehend developmental stages of recovery.
18. Become familiar with the Developmental BioPsychoSocial (DBPS) model for treatment and recovery for persons with a dual mental disorder other than a psychosis and a substance use disorder or addiction.
19. Know specific kinds of intellectual impairment and their implications for treatment and recovery.
20. Explore developing treatment and recovery processes helpful for persons with an intellectual impairment and addiction
21. Become aware of the incidence of physical impairment and rate of substance abuse among people dealing with a physical challenge.
22. Recognize barriers to recovery within the challenged individual, his community and in the treatment and self help environments.
23. Become aware of specific needs, which must be met, and the dialogue, which must occur between the challenged, and the presently able who are part of their potential service network.

COURSE ASSIGNMENTS:

Reading Schedule: This is a new course and because it is, student involvement in development of the course and exploration of materials is especially crucial in order to create together an environment of inquiry and discovery. The reading schedule consists of chapters and articles from texts available in the bookstore and a series of articles, which will be available on our electronic library, MERIT. You will find MERIT on the Marist Web site at "Library." Articles may be downloaded from MERIT at the Donnelly computer lab and the library across Rt. 9. MERIT was used for convenient, accessible, inexpensive access. Please let Jan

Mainzer of the library staff or me know if there are any problems with the system.

In addition to the articles, a course pack consisting of lecture outlines, bibliographies suggested Web sites and other resources will be loaded on MERIT as the staff is able to do so. The same resources in hard copy may be explored at my office.

Group Work: The class will self select itself into work groups at the beginning of the term. These groups are intended to help you explore the course materials in a smaller setting and to develop together written summaries, analyses, and reflections of the issues presently challenging the field of addictions' prevention and treatment.

Group essays I: After reading materials scheduled through February 11 and using resources in the course pack, each group is to write their analysis of the following: What is addiction? What is the relationship between addiction and mental illness? Due date: February 18

Group essay II: Choose one of the three client groups being considered in this course. Write a discussion of the unique challenges in working with clients with this particular double challenge. Due date: April 20

Meetings: Once permission is obtained, students will be able to sit in on a dual recovery meeting. As preparation, students are to attend one open AA or NA meeting and write a response. What is your overall emotional and thinking response to the meeting? What relapse factors do you hear in the meeting? Due date: February 9.

Journal: Each student is to keep a journal in which to explore thoughts, feelings, questions and concerns. A three to four page summary of the journal is due May 6.

Terms project: After examining the reading schedule and objectives, the class will determine the term project which would best help you meet the course objectives and engage your interest. Some possibilities include group presentations, papers, outreach projects with reporting. Your creativity is likely to produce the most interesting alternative.

Evaluation:
(Subject to discussion)

Group essays	15%
Journal	10%
AA meeting response	10%
Dual meeting response	10%
Midterm synthesis	13%
Final synthesis	12%
Participation/discussion	10%
Term project	20%
	100%

Text books:

McNeece, C. A. & DiNitto, D. M. (1998). Chemical dependency: A systems approach (2nd ed.). Boston: Allyn & Bacon.

Evans, K. & Sullivan, J. M. (1990). Dual diagnosis: Counseling the mentally ill substance abuser. New York: The Guilford Press.

Miller, N. S. (Ed.), treating coexisting psychiatric and addictive disorders. Center City, Mn.: Hazelden.

Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addiction and mental health problems. Independence, Mo.: Herald House/Independence Press.

Daley, D. C. & Thase, M. E. (1994). Dual disorders: Recovery counseling. Independence, Mo.: Herald House/Independence Press.

Spring 1999
Reading schedule:

Date	Topic	Readings
Thurs. Jan. 21	Course overview Addiction: A review and update	

McNeece, C. A., & DiNitto, D. M. (1998). Chemical dependency: A systems approach (2nd ed.). Boston: Allyn & Bacon. Chapters 1-4

Tues. Jan 26	Concept of concurring disorders and their challenges	

McNeece, C. A., & DiNitto, D. M. Chapter 13

Thurs. Jan. 28	Mental illness: Contributing factors	

(Instructor selected materials from the Human Behavior in the Social Environment, ecological perspective: Biological, psychological, social)

Tues. Feb. 2	DSM-IV: A typology of mental illness	
Thurs. Feb. 4	DSM-IV	

Williams, J. B. W. (1995). Diagnostic and statistical manual of mental disorders. In R. Edwards (Ed.). Encyclopedia of social work (pp. 729-739). Washington, D.C.: National Association of Social Workers.

Tues. Feb. 9	Relationship between substance use and psychiatric disorders The self-medication debate	

Meyer, R. E. (1986). How to understand the relationship between psychopathology and addictive disorders: Another example of the chicken and the egg. In R. E. Meyer (Ed.), Psychopathology and addictive disorders (pp. 3-15). New York: Guilford Press.

Miller, N. S. (1994). The interaction between coexisting disorders. In N. S. Miller (Ed.), Treating coexisting psychiatric and addictive disorders (pp. 7-21). Center City, Mn.: Hazelden.

Thurs. Feb. 11	Patterns of use and challenges for treatment and recovery among clients with specific disorders: Mood, psychotic, personality	

Evans, K. & Sullivan, J. M. (1990). Dual diagnosis: Counseling the mentally ill substance abuser. New York: The Guilford Press.

Ekleberry, S. C. (1996) Dual diagnosis: Addiction and Axis II personality disorders. The Counselor, March/April, 7-13.

Tues. Feb. 16	Overview: Components of recovery in dual diagnosis 12-Step Programs, Family and system work, collateral work, psycho-education, pharmacology, support
Thurs. Feb. 18	Daley's Phasic Supportive Model: Stages of recovery Assessment: Client and system

Daley, D. C. & Thase, M. E. (1994). Dual disorders recovery counseling. Independence, Mo.: Herald House/Independence Press.

Tues. Feb. 23	Developmental stages of recovery: Engagement and Stabilization
Thurs. Feb. 25	Developmental stages of recovery: Early, late, maintenance including work with collaterals
Tues. Mar. 2	Midterm exam
Thurs. Mar. 4	Pharmacology (guest lecturer in neuroscience and pharmacology)

Miller, N. S. (1994). Medications used with dually diagnosed . In N. S. Miller (Ed.), Treating coexisting psychiatric and addictive disorders (pp. 143 - 159). Center City, Mn.: Hazelden.

Tues. Mar. 9,	12 Step Programs

Dupont, R. E. (1994). The twelve steps approach. In N. S. Miller (Ed.) Treating coexisting psychiatric and addictive disorders, (pp.177-197). Center City, Mn.: Hazelden.

Thurs. Mar. 11	Family stabilization and wider system issues

Dixon, L., McNary, S., & Lehman, A. (1995). Substance abuse and family relationships of persons with severe mental illness. American Journal of Psychiatry, 152, 456-458.

Galanter, M. (1993). Network therapy for addiction: A model for office practice. American Journal of Psychiatry, 150, 28 - 36.

Knight, D. K. & Simpson, D. D. (1996). Influences of family and friends on client progress during drug abuse treatment. Journal of Substance Abuse, 8, 417-429.

Menicucci, L. D., Wermuth, L. & Sorensen, J. (1988). Treatment providers' assessment of dual-prognosis patients: Diagnosis, treatment, referral, and family involvement. The International Journal of the Addictions, 23, 617-622.

(See course pack on Family Systems by Richard Gelb for more resources)

Tues. Mar. 16 Thurs. Mar. 18	Spring Break
Tues. Mar. 23	Overview: Developmental BioPsychoSocial Model (DBPS) An emergent model

Chatlos, J.C. (1994). Dual diagnosis in adolescent populations. In N. S. Miller (Ed.), Treating coexisting psychiatric and addictive disorders (pp. 85-110). Center City, Mi.: Hazelden.

Thurs. Mar. 25	DBPS: Stages of Treatment and Recovery
Tues. Mar. 30	Post traumatic stress disorder: recognition, treatment, recovery

Ouimette, P.C., Wolfe, J. & Chrestman, K.R. (1996). Characteristics of post traumatic stress disorder-alcohol abuse comorbidity in women. Journal of Substance Abuse, 8, 335-346.

Thurs. Apr. 1	Intellectual impairment: Definitions, etiology and incidence

Genne-Phillips, M. (1993). Treating a special population: The developmentally disabled. Addiction & Recovery, winter, 21-23.

Tues. Apr. 6	Intellectual impairment and AOD use: Motivation, effects, patterns
Thurs. Apr. 8	Intellectual impairment and challenges to treatment and recovery: The need for new approaches
Tues. Apr. 13	Intellectual impairment: Building a model for recovery
Thurs. Apr. 15	Intellectual impairment: The road to better living

Tues. Apr. 20 Physical challenge and AOD use: Incidence, patterns, access to treatment and recovery

Moore, D., Greer, B.G., Li, L (1994). Alcohol and other substance use/abuse among people with disabilities. pp 369-382 in Dunn, S.D. (Ed.). Psychosocial perspectives on disability. Journal of social Behavior and Personality, 9, Corte Madera, Ca: Select Press and additional articles as selected

Materials from Rochester Institute of Technology, Substance and Alcohol Intervention Services for the Deaf- See course pack

Thurs. Apr. 22 Physical challenge: Opening doors to recovery

Tues. Apr. 27 Physical challenge: Recovery and specific needs

Thurs. Apr. 29 Field trip: Tentative

Tues. May 4 Student presentations

Thurs. May 6 Student presentations

Office hours: Please make appointments for these and other times

Monday	No hours		
Tuesday	8:30 AM - 9:15 AM		
	12:30 PM - 1:45 PM		
Wednesday	9:30 AM - 10:45 AM		
Thursday	8:30 AM - 10:45 AM		
	12:30 PM - 2:00 PM	Friday	Please make an appointment

Group work:

First student proposals for group term projects were introductory and largely unrelated to the content of this course. They had little enthusiasm for writing and discussing the life struggles of persons who are mentally ill, intellectually impaired or physically challenged as well as addicted. They had to first overcome stereotypes about addiction. Over the semester, they became deeply involved in understanding the issues of individuals facing multiple challenges. Students without prior knowledge in the field need more structure to help them develop projects.

Psychiatric diagnosis as a concept:

The students' exposure and response to psychiatric concepts such as diagnosis varied greatly. Even though my own work experience outside the classroom is in mental health, I wanted the students to be cautious about labeling and to recognize the power differentials associated with labeling and being labeled. Social work students had no background in the use of the DSM (Diagnostic and Statistical Manual), because our program is generalist. J.B. Williams provides a good basic introduction to the Diagnostic and Statistical Manual. Meyer provides an excellent introduction to the interface between mental illness and addiction. Even so, these undergraduate students were not ready to digest these articles in full. They needed a slow pace carefully outlined and illustrated by cases. The students responded best and felt most competent when they could study cases.

Martha Mashburn, CSWR, and the MICA client:

Four weeks into the course, the students benefited from four structured sessions taught by Martha Mashburn, then MICA treatment coordinator for Dutchess County Department of Mental Hygiene. She used her work experience and Dennis Daley's model for treatment of the severely disabled psychiatric client who is also addicted. The students especially liked the composite cases she developed to help them recognize the presence or absence of mental illness and addiction. Though composite, these cases are considered too confidential to put into print. As their diagnostic skills improved, the students' enthusiasm increased.

The students admired Ms. Mashburn's professional, informed, caring approach to her work with mentally ill, addicted clients. They glimpsed the exacting nature of the work. Ms. Mashburn provided a role model, a possible professional model. They began to realize that with education, training and experience, they too could work in this field. We were nearly at the midpoint in the course. The students had read and were ready to discuss and debate points and to ask questions formed from their reading and beginning integration of the material.

Overheads derived from Dr. Dennis Daley's work are included in this discussion.

*EARLY RECOVERY

GENERAL

High structure/support
External controls
Dependent on professionals

*MENTAL ILLNESS

Some ongoing symptoms
Adjustment to mends
Monitored medication
Brief decompensation under stress
Begin to identify stressors
Begin to identify prodromals

*SUBSTANCE ABUSE

- **Occasional relapses with periods of sobriety**
- **Intense AA involvement**
- **Intense contact with sponsor**
- **Steps one, two & three**
  "People, places & things"

***CLINICAL** **Intensive services** **Minimal stress** **Here & now** **Minimize change** **Educational** **Assertiveness training**
HOUSING **Community Residences**
VOCATIONAL **Sheltered work** **Psych rehab**
LEISURE **Organized externally**

* Developed From: Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addition and mental health problems. Independence, Mo.: Herald House/Independence Press. By : Martha Mashburn, CSWR

*

MIDDLE RECOVERY

GENERAL

Some structure/support
Controls with guidance
Some professional guidance

. Developed From: Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addition and mental health problems. Independence, Mo.: Herald House/Independence Press. By : Martha Mashburn, CSWR

*MENTAL ILLNESS

Symptoms when under stress
Medication may be reduced
Self-meds with occasional supervised counting
Can identify stressors & prodromals with support - still reactive

SUBSTANCE ABUSE

Slips with substantial periods of sobriety
Less intense AA involvement and contact with sponsor
Continue steps one, two & three
Identify relapse triggers

*   **CLINICAL**   **Reduced services**   **Explore feelings**   **Begin to look at losses**   **Develop ways to cope**   **Can be assertive with support**
HOUSING   **Supportive residential**
VOCATIONAL   **VESID**   **Education**
LEISURE   **With guidance**

* Developed From: Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addition and mental health problems. Independence, Mo.: Herald House/Independence Press. By : Martha Mashburn, CSWR

LATE RECOVERY*

GENERAL

Support/structure PRN
Internal controls
Independent

---

* Developed From: Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addition and mental health problems. Independence, Mo.: Herald House/Independence Press. By : Martha Mashburn, CSWR

*MENTAL ILLNESS

Stable accept under extreme stress
Self-meds or no meds
Preventive measures to cope with/handle stress

---

* Developed From: Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addition and mental health problems. Independence, Mo.: Herald House/Independence Press. By : Martha Mashburn, CSWR

SUBSTANCE ABUSE

Long term abstinence
Ongoing AA
May be sponsor for newcomer
Steps four & five
Review relapse triggers

CLINICAL*

May be meds only with other services PRN
Lifestyle changes
Resolve "character defects"
Work on relationship issues
Can be independently assertive

---

*

*HOUSING Independent residential with financial assistance
VOCATIONAL Competitive employment
LEISURE Independent leisure skills

* Developed From: Daley, D.C. (1994). Dual diagnosis workbook: Recovery strategies for addition and mental health problems. Independence, Mo.: Herald House/Independence Press. By : Martha Mashburn, CSWR

*EARLY RECOVERY	MIDDLE RECOVERY	LATE RECOVERY
General High structure/support External controls Dependent on professionals	**General** Some structure/support Controls with guidance Some professional guidance	**General** Support/structure PRN Internal controls Independent
Mental Illness Some ongoing symptoms Adjustment to meds Monitored medication Brief decompensation under stress Begin to identify stressors Begin to identify prodromals	**Mental Illness** Symptoms when under stress Medication may be reduced Self-meds with occasional supervised counting Can identify stressors and prodromals with support still reactive	**Mental Illness** Stable accept under extreme stress Self-meds or no meds Preventive measures to cope with/handle stress
Substance Abuse Occasional relapses with periods of sobriety Intense contact with sponsor Steps one, two & three "People, places and things	**Substance Abuse** Slips with substantial periods of sobriety Less intense AA involvement and contact with sponsor Continue steps one, two and three Identify relapse triggers	**Substance Abuse** Long term abstinence Ongoing AA May be sponsor for new-comer Steps four and five Review relapse triggers
Clinical Intensive services Minimal stress Here and now Minimize change Educational Assertiveness training	**Clinical** Reduced services Explore feelings Begin to look at losses Develop ways to cope Can be assertive with support	**Clinical** May be meds only with other services PRN Lifestyle changes Resolve "character defects" Work on relationship issues Can be independently assertive
Housing Community residences	**Housing** Supportive residential	**Housing** Independent residential with financial assistance
Vocational Sheltered work Psych rehab	**Vocational** VESID Education	**Vocational** Competitive employment

DUTCHESS COUNTY MICA RESOURCE GUIDE

SERVICES	MICA SPECIFIC	Detox/Rehab	PHONE #	MICA SENSITIVE	Detox/Rehab	PHONE #
In-Patient Services	Benedictine Hospital, Kingston	Yes/No	338-2500 X4300	Leonard Hospital, Albany	Yes/Yes	1-518-583-7076
	United Hospital, Port Chester	Yes/Yes	914-934-3135	Graymoor, Garrison	No/Yes	424-3616
	Liberty Health Care	Yes/Yes	1-800-662-5800	Conifer Park, Schnectady	Yes/No	1-800-989-6446
	Nyack Hospital, Nyack	Yes/Yes	1-800-922-5535	Turning Point, Beacon	Yes/No	831-3500
	St. Vincent's, Harrison	Yes/Yes	914-976-6500	Rhinebeck Lodge, Rhinebeck	Yes/No	266-3481
	Middletown ATC, Middletown	Yes/Yes	342-5511 X3163	St. Francis Hospital, Poughkeepsie	No/No	471-2000
	NY Hospital, White Plains	Yes/Yes	682-9100	Kingston Hospital	Yes/Yes	331-3131 X2466
	Four Winds, Katonah	Yes/Yes	763-8151	St. Peter's, Albany	No/Yes	1-518-525-1550
	Craig House, Beacon	Yes/Yes	831-1200			
	MARC ACC Poughkeepsie	Yes/No	471-0310			
	Phelps Hospital	Yes/Yes	366-3000			
Out-Patient Services	DCDMH - Various clinics & day treatment sites		485-9700	DCDMH - Various clinics & day treatment sites		485-9700
				Step One, Highland		691-9191
				CHP		486-3570
Day Services	MHA - The Living Room		471-9431	MCCDC Day Reporting		
	DO - Lunch Box					
	DC Comm. Action - Copmm. Resource Center - Beacon		452-5104			
Consumer Services	12 Step Double Recovery		471-2000	PEOPLe		452-2728
	AA/NA - HRPC		452-8000	MHA		473-2500
				12 Step AA/NA - Generic		452-1111
Residential Services	MCCDC - 15 Unit HUD/OMH S.H. S & C		471-4987	HRPC - Highview & Haven House SOCR		452-8000
	HRPC - SOCR - Edgewood		452-8000 x7776	Daytop - TC		876-5400
	UCMHA - Tuytenbridge CR		339-9090	MARC - 1/2 way & 3/4 way houses & S.H.		452-9168
	Odessy House - TC, NYC		1-212-477-9493	HRH, Hillcrest, Maximize, HUD/OMH S.H. S & C		454-5176
				MCCDC - CR, SLAP, SH, ATI		471-4987
				RSS - CR, SLAP & SH		485-2117
				St. Joseph's Guest House		1-518-891-3950
				Gateway - CR & SH		331-1261
				Hedgewood PPHA		831-6000
				Various other private providers		
Vocational/Educational Services	ARC/DC - MICA Job Coach		454-8854	NYS - VESID		452-5325
				HRPC - Center For Change		452-1348
				HRPC - GROW, Po'k. & DC/DMH GROW - SDCTC (897-2011)		452-1348
				Gateway CI		331-1261
				Rehab. Programs, Inc.		485-9803
Specialized CM Services	DCDMH - ICM		486-2700	ARCS		1-800-992-1442
				DCDMH - CM		486-2700
				DCDMH - SST		486-3700
				DSS - APS		486-3000
Crisis Services				Dutchess Outreach		454-3792
				HRH - DCCH - Gannett		452-0019
				HRPC - Crisis Residence		452-8000
				MCCDC - ICM - Respite Bed		486-2700
				DCDMH - Helpline		486-2700
				SFH - EPCC		471-2100
				Grace Smith House		471-3033
				MARC Alcohol Crisis Center		471-0310

Leisure	**Leisure**	**Leisure**
Organized externally	With guidance	Independent leisure skills

Avoiding pitfalls:

One of the pitfalls of an overview course with so much content is pushing too much material. Students need time to discuss the material in order integrate it. This also provides faculty with a chance to see students in action, to see how far they have come. It is more important for the student to understand some things well than to know about many things and to lose interest in the topic.

Evolution of the course during the term, a special guest:

The course evolved over the semester. On March 17, I attended a MICA Task Force meeting in Orange County. The meeting was filled with enthusiasm and energy. I knew when I heard patient advocate Cheryl Conley speak, she would be a wonderful addition to the course. She agreed to do a session on Double Trouble, the meetings she helped begin in Orange County. Ms. Conley's frankness and experience provided a significant turning point in the course. She made the plight of the mentally ill and chemically addicted person real. The students were riveted by her dramatic presentation and her true to life stories. Things were not the same after she shared. No one could hide behind clinical labels. Students began to tell family and friend experiences.

Testing:

Planning for student examination was not easy. The students wrote suggestions for the midterm exam based on their estimate of the material they felt most qualified to discuss. All wanted to read and assess cases. The exam did include cases. My first attempt to write an exam for this course follows. It successfully distinguished students who attended class, took notes, read, and studied.:

Addictions and Special Populations Cheryl Whitley, CSWR,PhD
Midterm examination, March 4, 1999

Please write your responses in the booklets provided.

---

1. Louis, a junior at Marist, likes to party. "It's true," he thinks, "Everybody told me that I would be able to handle my drinking better when I'd been at school longer." Now Louis can drink 6 beers in a sitting and not stagger at all. In fact, that feels about right. When he was a freshman, three beers was about his limit. He rarely drinks into black out. He did lose some time after the big party a few weeks ago, but he figured that was because he mixed beer and whiskey. Lately, he's found that a little marijuana feels pretty good when he's drinking. He looks down on students who are using cocaine. He says they're "low lifes". He's usually the designated driver, because his friends admire his good head for liquor. It's true that Louis' girlfriend of 8 months broke up with him last month. She told him he needed to grow up, and she needed someone who would pay attention to her. Louis is trying to get off academic probation. He really means it this time, he says. He vows to cut his drinking down to two

days a week, but he finds that he begins to get irritable if he doesn't go out on his usual schedule. He also finds he can't sleep well. His room mate tells him he thinks he should go to the student counseling center to discuss his drinking. "What's to discuss," says Louis, "I'm having a good time and anyway, I have plenty of time to cut back after I graduate."

24. What if any symptoms of addiction do you hear in Louis' story?

25. What is the Diagnostic and Statistical Manual IV? How is it organized?

26. What, according to Miller, is a mental disorder or illness?

27. Discuss Meyer's statement that risk factors for mental illness and addiction may interact or overlap.

5. List and briefly describe the phases of Daley's Phasic Supportive Model for Treatment of the client suffering from two disorders, addiction and mental illness.

6. For each of the following case descriptions, state (1) is this a dual diagnostic case? If you are not sure, state your reasons. (2) the phase of Daley's treatment process which coincides with their present needs and (3) the type(s) of treatment which would be appropriate for their needs.

A. Adriane is a 22-year-old white female. She was released last week from the inpatient psychiatric unit at Home Town Hospital. She was released with a two-week supply of oral anti psychotic medication and another two-week supply of antidepressant (new style, serotonin re uptake blocker). She has not been able to complete her college education due to 6 hospitalizations for severe depression with psychotic features. She has attempted suicide twice. She self mutilates. Adriane lives at home with her mother. She does not work and spends a great deal of time alone in her room listening to metal rock. She dresses in the garb of a rocker, wears black, has body piercing and a leg tattoo. Addriane's father died when Adriane was 4. Adriane's mother also has suffered from severe depression currently in remission with medication. Adriane does not want to take medication. She uses marijuana at least 3 times a week to regulate her mood. She has also found that she likes to use "uppers," various prescription medications that she gets from her friends. She experiments with any type of drug offered to her. In all her hospitalizations, no one has taken a complete drug and alcohol history. She has never persisted in psychotherapy more than 3 months. She is scheduled to see the intake worker at the Dutchess County Department of Mental Hygiene.

B. Daryn is a 20-year-old college student. He began experiencing symptoms of psychosis when he was 18. He has been diagnosed as suffering from schizophrenia. He is aware of his diagnosis and is compliant with his medication. Prior to his diagnosis, he had used marijuana weekly from the

age of 15. He is also alcohol dependent from the age of 16. Daryn has been abstinent from alcohol and other drugs for three months. He attends AA 3 times a week. He takes a reduced course load. He is in a support group at the mental health center where his symptoms are monitored and he receives help with socialization with others.

C. Helen is a 45-year-old divorced and remarried woman with two children ages 8 and 10. She suffers from borderline personality disorder and alcoholism. In the past, she suffered from recurrent depressions, but those have been relieved, since she became involved with her church and attends a weekly support prayer group. She works part time as a free lance writer. She has had recent successes with her publications. In addition, with support from a parenting group, she has been able to raise her children without physically or mentally abusing them as she had experienced growing up. Helen continues in individual treatment, but is able to reflect about her crises without impulsively calling her therapist. She does not take medication. At this time, Helen attends one to two AA meetings per week. She has been abstinent from alcohol or other drugs since her first pregnancy. Her mood is generally positive, and she is able to credit herself with her successes. Helen's husband is supportive and reports being happy in their marriage.

Pharmacology

The students needed basic understanding of brain function. They also needed to know about new developments in pharmacology. They had access to materials developed by Dr. Tin Chin of the Dutchess County Department of Mental Hygiene. (See the 1998 course pack for this course.) Marist College professor, Sherry Dingman Ph.D., physco-psychologist, taught a primer on brain function and pharmacology. This session should be early enough in the term to provide background for the discussion of the mica client. This session is not easy to staff unless the instructor is well versed in brain physiology. Knowledge is expanding at an incredible rate, so the speaker should have current information. It is easy to mistake old films on this topic for useful information, because new studies refute the old. At this writing, Bill Moyers' The Hijacked Brain is helpful. The special issue of Alcohol Health and Research World, Vol. 21, number 2, 1997, provided helpful background up to the point this course was taught.

Ecosystem Module:

Richard Gelb, Director of the Nyack Hospital Recovery Center, and Annette Bonet, Intake Coordinator, presented the Eco systems module at this point. Their presentation provided a broader lens and helped the students shift from a micro view of pathology to look at the effect of individual, family and professional beliefs on the course of life and recovery. The students received their teaching well. Mr. Gelb's discussion centered on the nature of change, the ecosystem, and beliefs. A key question he raised was, Do you believe you know what is

best for you? He also asked, Does the patient know what is best for him? What are your beliefs about change? What kind of shifts must YOU make in order to create a FIT between you and the client? I must change as well as expect the client to change. See Richard Gelb's discussion of the ecosystem model in this course pack for an elaboration of the perspective.

At the end of many sessions, I asked the students to respond anonymously in writing by completing the following sentences: Today I learned . . . Right now I feel . . . Next time I hope. These responses I learned from Carol Turner, PhD, Highland Park, NJ. This type of immediate writing allows the student to get in touch with his/her thoughts and feelings on the spot. That is good for life and for clinical work. The responses allow me to take the class temperature to see if there are any emotional casualties, whether the pace should be increased or slowed, and what type presentation is most useful. Not all students complete the exercise, but they have reported its being helpful. The following are the student responses from the Ecosystem session:

Today I learned that the client really does know what is help for him/herself. How as a social worker, I can Change my thinking. Right now, I am grateful to the speakers for sharing with us. Next time I hope I can learn half as much as I learned today.

Today I learned a great deal about change and how much it involves. Change takes respect when dealing with clients. Right now I feel overwhelmed. There was a lot of information. Next time I hope I will apply all this to the information.

Today I learned the concept of context. Right now I feel overwhelmed by today's

lecture. Next time I hope not to feel overwhelmed.

Today I learned that the care giver needs to work with the client to find out what is best for the client. One should never force their beliefs on another. Right now I feel intrigued and am willing to learn more. I hope that more is studied on this, because treatment needs to be looked at too.

Today I learned that the therapist's attitudes are just as important as the identified patient. Otherwise, like being a consumer in a store, if that store didn't have the merchandise I needed, and they were trying to tell me it was best for me, I'd leave the store. Right now I feel confidant about going into the working field of psychology, knowing that the interaction between client and therapist is crucial. Next time I hope we learn more of the counseling end. What questions to ask-how we can help bring about the change.

Today I learned that there is a vital importance inn the relationship between client and therapist. It is so important that you cannot enforce change on a patient, but rather the patient must be ready for change. Right now I feel that I would like to stay in this field after I graduate. I hope that I can be of use in the helping profession by listening to the stories of patients and having some impact on them.

Today I learned that you only know what is best for you. You cannot decide for other people what is best for them, because you have not walked in their shoes and have not experienced what they have. Right now I feel that change is important and you can only change for yourself. I hope that more people learn that they cannot decide what is best for other people.

Today I learned that the therapist doesn't always know what is best for the patient.

Now I feel that there is a special relationship that must work between a client and social worker.

Today I learned a lot about change and working with clients that need change. Right now, I feel like I need to reflect on myself and my own ways of change and coping. I also want to say that even though you(the presenter) tough with us, you force us to learn and I think that's good. Next time I hope to learn more and meet clients.

Visit to Nyack Hospital Recovery Center:

The students were eager to see the hospital and meet the clients. I moved up the scheduled field trip. In retrospect, the field trip does need to take place soon after midterm, but it should be scheduled and remain steady in the syllabus. That way, more students will make any planned trip. A working visit to a treatment facility is important to the course. The March 25 Nyack trip was ideal, because it involved not only touring, but interaction with the clients and staff. Students heard planned lectures. Anthony Porter, Director of the Nyack outpatients' facility, discussed the eco-systemic approach to delivery of services. Annette Bonet discussed the admissions process as a contextual event. Dr. Stephen Kipnis, MD, Medical Director, discussed the physiology of addiction and treatment. Steve Oswald, Case Manager, discussed treatment planning and the team concept. Students signed confidentiality statements and were allowed to participate in a patient "beliefs" group. Patients shared their beliefs about change and recovery. The students were amazed at the clients' awareness and ordinary appearance. They were mesmerized by this session, but they also took risks and talked about their own beliefs. The hospital provided lunch. This was followed by the students being allowed to hear the case reviews for the day. They were surprised at the diverse

orientations represented among the staff..

I am convinced that the students did not read the articles in the syllabus related to the title, Family stabilization. In fact, I will change the readings for this section or I will structure their use more carefully. Undergraduates need more structure to attack research-based articles. See this course pack in the Ecosystem section for other references that will be helpful. I am looking forward to reading a new book by Stephanie Brown and Virginia Lewis entitled *The Alcoholic Family in Recovery*, Guilford Press, 1999.

The Developmental BioPsychoSocial Model:

Having taken a course at the Rutgers Advanced School of Alcohol and Drug studies in 1998 with Dr. J. Calvin Chatlos, I included his model in order to introduce the students to a different approach to treating non-psychotic but disturbed addicted adolescents. The material for this section is contained in the 1998 course pack available from ATTC. Dr. Chatlos' materials are dynamic and useful for teaching the connections among predisposing factors, use of AOD as an event, concomitant factors, and sustaining environmental factors. His integration of mental health and recovery models is, I believe, one of the most hopeful developments in addiction treatment.

Trauma:

I have an interest in trauma and see it as a pivotal factor in addiction and recovery; therefore I included it in this course. I drew upon my own training, study and reading in this area. I recommend readings by Charles Figley, Yael Danielli, and B.A. van der Kolk. The students were interested in the concept trauma and wanted to dig more deeply into this area.

Intellectual impairment and addiction: Mary Genne Phillips, MS, CASAC, Dutchess County Department of Mental Hygiene, 7 Mansion Street, Poughkeepsie, NY 12601, 914-486-3700, Guest Lecturer. See also 1998 course pack for this course.

Because Mary Phillips is one of the few practitioners developing treatment processes with the intellectually impaired addicted client, I will provide with her permission some more detail in this area. Ms. Phillips works with a client population who are considered "seriously and persistently mentally ill and intellectually impaired" (SPMI) in a project funded by the Office of Alcohol and Substance Abuse Services (OASAS), Office of Mental Health (OMH), and Office for Mental Retardation and Developmental Disability (OMRDD).

Persons with mental illness and intellectual impairment were not succeeding in detoxification or rehabilitation facilities and were not entering recovery. Three problems faced the builders of the project in Dutchess County that was developed by Jeanette Powell: identification of the client population, creating skills and program, and the barriers of historical treatment of the intellectually impaired. Names like "moron" and "idiot" were road blocks.

Historically, intellectually impaired persons have been institutionalized; therefore they had little contact with alcohol or other drugs. Now that less restrictive alternatives are sought for intellectually impaired persons, access to drugs is part of the reality. Case finding began with agencies who serve the mentally ill intellectually impaired. The "current biggest source" of clients is from the criminal justice system. Jails have become holding tanks for addicted, mentally ill, and intellectually impaired persons. These persons face three overwhelming

problems with little support. Staff in jails and prisons have little or no training to help them serve or cope with persons suffering so much dysfunction. On the other hand, keeping patients off the street may seem cruel, but it has also saved lives. The jails are filling the gap left by deinstitutionalization, says Ms. Phillips.

Ms. Phillips engaged the students in reflection on their recollection of children they remember, "Do you remember retarded kids?" The discussion was lively and highlighted the abuse and neglect of intellectually impaired children within communities and school systems.

Diagnosis of mental illness among intellectually impaired persons is often overlooked. Stereo typically, we expected these clients to behave peculiarly. For example, explained Ms. Phillips, a child with Downs' Syndrome was mainstreamed in the traditional classroom. He became despondent while trying to keep up with the environment. He then drank alcohol in an attempt to feel better. Depression is overlooked in intellectually impaired persons.

Ms. Phillips engaged the students in considering what roles intellectually impaired persons can fulfill in the community. They can be part of the community as members, teachers, sponsors, or detrimental to the community by being criminal. With disguised and invented case histories, Ms. Phillips helped the students to understand that persons with three distinct disorders, addiction, retardation, and mental illness are heroes if they merely survive. She gave vivid details of the disastrous outcomes of unplanned deinstitutionalization. When the Dutchess County project was created, identification of the client population followed. To date, ninety-five clients have been served.

Intellectually impaired persons have a number of traits that inhibit understanding and applying the principles of addiction recovery. Mental illness further complicates the struggle.

Reasoning and logic are impaired; therefore understanding rules and patterns is extremely difficult. Judgement is often limited, so clients are vulnerable and often do not act in self protective ways. Clients lack understanding of social rules, so they violate cultural norms. For example, clients stand "too close" to others. Clients are impulsive and do not stop to consider consequences. Time is a vague idea; therefore sequence and history are confused. Yesterday and nine years ago may be the same. Persons with intellectual impairment often have little sense of self worth. Rejected by society, they see themselves as worthless to others. Often these clients have little sense of self control; others have managed their lives, so decision making skills are undeveloped at best.

The intellectually impaired person has few motivators for sobriety. Family or job loss or threat of loss are usually missing. Few retarded persons are married or raising children. Most truly intellectually impaired persons are receiving financial grants that are not threatened by their alcohol or drug use. Cognitive connection of drinking and consequences is a difficult or impossible leap for most people suffering intellectual impairment. Seeing the need for self care is limited. Why get sober? Mandated clients who enter the program often return, because "It's a good place to come," said one of Mary Phillips' clients. The fellowship, encouragement, learning, and even the fun of the program keep clients returning, and slowly the idea of sobriety gains meaning and significance. The operative word is slowly.

Mary Phillips closed her discussion with case presentations that further assisted the students. They came to care about these clients who are the least favored among most practitioners. They gained appreciation for the struggles of the people suffering the triple threat, retardation, addiction and mental illness.

Student responses to Mary Phillips' presentation concerning persons with intellectual impairment, mental illness, and addiction:

Today I learned more about mentally retarded/chemically addicted. Right now I feel knowledgeable on new issues. When I think if working with these people, I feel eager to see the differences between the populations and eager to learn new things.

Today I learned the importance of the serenity prayer. Right now I feel bad for those who are clueless. Next time I hope to interact as a class more. When I think about working with the population, I get a little scared.

Today I learned that you need to assess mentally retarded people differently. Right now I feel really inspired by the people who are mentally retarded and want to change, and go through sobering up. When I think about working with this population, I think you need a lot of patience, and I don't know if I could do it. It takes a long time to see progress.

Today I learned that mentally retarded people are very similar to the population as a whole, though they are challenging and you should never talk down to them and always show them respect. Right now I feel that this group would be a huge challenge to work with. Next time I hope to learn more about engaging this population into counseling. I think I would not feel comfortable working with this population.

Today I learned that it is possible for mentally disabled individuals who are addicted to get help, but that it is hard to acknowledge the problem. Right now I feel optimistic that if anyone has a problem like addiction, he or she can get help. Next time I hope to learn more about the treatment of mentally disabled and addicted. I feel we touched base toady, but I think we need to go more in depth. I work with mentally disabled people and I enjoy it, so I think I would greatly enjoy working with mentally disabled and addicted.

Today I learned how difficult it is for intellectually impaired individuals to grasp the concepts to help themselves that seem so easy to me. Right now I feel grateful. Next time I hope to learn more about treatments. When I think about working with this population, I realize how talented the staff must be as well as how patient.

Toady I learned that it is difficult to help clients who are addicted and mentally retarded because they do not understand what is really going on in their lives. Right now I feel scared to work with this population. Next time I hope to learn more about treating this population. When I think about working with this population, I think it would be very interesting, rewarding and challenging.

Today I learned how to talk to and treat a person who is retarded. Right now I feel like I can be more comfortable to be around people like we talked about. Next time I hope to learn more when I think about working with this population, I have more confidence.

Today I learned that mentally ill and/or mentally retarded people can and do change and can get over drug addiction. Right now I feel a sense of hope for mentally retarded/mentally ill chemically addicted. Next time I hope to learn more about this population. When I think about working with mentally ill/mentally retarded chemically addicted, I honestly believe that I would need a lot of patience and strength.

Today I have learned a better understanding of how to treat people who are intellectually impaired and have an addiction to drugs or alcohol. I better understand where they are coming from; what they have in their life and don't have. Right now I feel like maybe I will be able to work with this population. Next time I hope to learn even more about the treatment routine of intellectually impaired and chemically addicted. When I think about working with this population I get a little overwhelmed, but I am beginning to feel a little more comfortable and able.

Today I learned that there is hope for these people. Right now I feel better knowing that . When I think about working with this population, I feel hope for them.

I learned a lot from your lecture, a lot of new information about people who are developmentally disabled. Right now I feel happy that I've learned something new. Next time I hope to learn more. When I think about working with this population, I think it would be a huge accomplishment.

Today I learned about the pressures of going through life being addicted and being mentally ill. Right now I feel tired. Next time I hope to learn more. When I think about working with this population, I feel sorry for them.

Today I learned about the constant struggle that mentally retarded and chemically addicted people go through. These last three classes have created a better understanding for me. Right now I feel as if there needs to be more work done with these people. Next time I hope that there is more acceptance by society for these types of people. When I think about working with this group it seems lie a great deal of work, but it would be very rewarding.

Today I learned really how hard it is for the mentally retarded to overcome addiction. There are so many barriers. I would like to be able to help this population, because I think that they have potential and are special and they shouldn't succumb to addiction. Right now I feel that I really want to help these people. Next time I hope that we can learn more about treatment for this group. When I think about working with this group, I get overwhelmed, because there is so much to the individual.

*FEDERAL DEVELOPMENTAL DISABILITIES LEGISLATION

Public Law 95-602 Definition of developmental disability

"A severe, chronic disability of a person which is attributable to a mental or physical impairment or combination of mental and physical impairments, is manifest before age 22, is likely to continue indefinitely. Results in substantial functional limitations in three or more of the following areas of major life activities:"

Self-care

Receptive and expressive language

Learning

Mobility

Self-direction

Capacity for independent living

Economic self-sufficiency

Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.

Diagnostic criteria for mental retardation

1. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test.

2. Concurrent deficits or impairments in present adaptive functioning (the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the flowing areas:
use of community resources
self-care
social/interpersonal skills
home living
self-direction
functional academic skills
Work, leisure, health and safety

---

* By permission of Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene

DIFFERENCE BETWEEN MENTAL RETARDATION AND MENTAL ILLNESS

Many people make the common mistake of confusing the mentally retarded person and the mentally ill person. However, it is most important to understand that these disorders are separate and distinct conditions. The following char compare the differences between the two.

MENTEL RETARDATION	***Differs from***	*MENTAL **ILLNESS***
Retardation refers to sub-average Intellectual functioning.		*Mental Illness has nothing to do with IQ. A person who is mentally ill may be a genius or may be sub-average*
Retardation refers to impairment is social adaptation.		*A mentally ill person may be very competent, socially but may have a character disorder or other aberration.*
Retardation usually occurs during the period of development or is present at birth. However, a brain injury or toxemia may cause retardation in anyone at any age.		*Mental illness may strike at anytime*
In mental retardation, the intellectual impairment is permanent but can be compensated through development of the person's potential		*Mental illness is often temporary and in most cases is reversible. It is not a developments disability.*
A retarded person can usually be expected to behave rationally at his operational level.		*A mentally ill person may vacillate between normal and irrational behavior.*
A retarded person will not be violent except in those situations that cause violence in non-retarded persons.		*A mentally ill person may be erratic or even violent.*

---

* By permission of Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene
Georgia Association for Retarded Citizens, ***Police Education Manual, P.6***

A mentally retarded person has a learning disability and uses the skill of educators, psychologists and vocational rehabilitation technicians

KEY CONCEPTS TO CONSIDER WHEN WORKING WITH THE MILDLY MENTALLY RETARDED SUBSTANCE ABUSER

Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene

Developmentally disable person are adults, have special skills, deserve respect.

Always emphasize the things that they CAN do.

Set realistic goals that can be achieved in very small steps.

Reward small successes.

Don't worry about being repetitive - it enhances the learning process.

Provide structure in treatment - help the client structure his life.

Speak in short, one concept sentences, use words that can be understood, but do not talk down to an intellectually challenged person.

Do not ask the person if he understands. He will always say "yes". Instead, ask him to tell you what that means to him. If he hasn't "gotten" the idea, re-structure your sentences and be mindful of you vocabulary.

Do not include the following as a goal: "patient will obtain a G.E.D." It is not realistic.

It isn't always necessary to develop insight in order to get clean and sober.

Be flexible. What works for one person might not work for the next.

Don't even think of sending your patient to a 12 step meeting without first providing information, social skills, and an "old-timer" to go along.

Do not assume that because a person knows African-American slogans that he is benefiting from the program.

Provide an alternative to African-American/NA.

It is very difficult for a person with a developmental disability to understand analogies.

Sometimes it takes a while before you can actually see the person's intellectual deficits.

Confrontation is OK, but tone it down.

In a word, "RESPECT" is what works the best.

---

* *By permission of Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene*

SUGGESTIONS:

? ***Language*** - *Constantly check for understanding. Don't automatically assume the client understands the words you are using.*

Therapist needs to be concrete and specific.

? ***Active-interactive Approach*** - *to sustain attention*

? ***Repetition***

? ***Treatment Goals*** - *small, simple, reachable understandable to client*

Goals need to be behavioral, measurable, and diagnosis specific.

---

* *By permission of Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene*

Community Twelve-Step Programs For The Developmentally Disabled

Positive Aspects	***Negative Aspects***
Camaraderie	*Feel "left out"* *Social skills could be deficient*
Black and white goal	*Can't read list, can't find the church*
Meet sober people	*Reluctant to engage in conversation because of "feeling different" or because of articulation disorder*
Meet sober people	*Often unable to make the leap from another person's story to their own situation - it is rare for person with MR to understand*
Entertaining stories	*An analogous situation*
	Unable to grasp meaning
	Generally to abstract

* *By permission of Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene*

*Myths About People With Mild Mental Retardation

Mentally retarded people:

? Are very similar to each other;

? Live in supervised environments such as "group homes" or institutions;

? Have family or care-givers or others to help them with activities of daily living;

? Are easily identifiable either by facial or other physical characteristics;

? Attended a "special school";

? Are unable to read or write;

? Think and comprehend the same way that non-disabled people do - only slower

? Can attain the same goals as those they perceive as "normal" - such as owning a fancy car, a fancy home, or having a family life such as is portrayed on TV - as long as they work hard enough; are less vulnerable to stressors then are the non-disabled;

? Cannot have addictions;

? Cannot be involved in criminal activity;

? Need to develop insight;

? Are not likely to have a mental illness;

? Cannot benefit from therapy;

? Can be Mainstreamed or "included" into traditional self-help or treatment modalities;

---

* *By permission of Mary G. Phillips, MS, CASAC, Dutchess County Dept. of Mental Hygiene*

Addictions and Physical Challenge

Few programs include discussions of physical challenges and addiction. In this section of the course, students were able to consider what, for many of them, was an entirely new idea. We were fortunate to have one enrolled student who has a physical disability and speaks readily about the challenges and strengths associated with it. I introduced the idea of physical challenge and addiction using the outline contained in the course pack for this course. Overhead foil masters follow this discussion.

This discussion became real and gripping when Steve Shevlin, MSW, Director of Signs of Sobriety (SOS), along with his interpreter and SOS staff member, Rita Gilbert, joined the class for a session. Steve became deaf as an adult. His simply telling the story of encroaching deafness and accompanying drug use had the class riveted to his face and hands. For Steve, deafness saved his life by providing a new challenge. Signing, he said, forced him to become emotionally vulnerable, because he could not hide. Students who had said deaf persons can just stay among deaf persons changed their attitudes. They were engrossed in considering ways to open 12 step programs to the hard of hearing.

Persons with experience working with the deaf and hard of hearing are the best source to equip the teacher and students with necessary information. Signs of Sobriety with their speakers and film, Silent Suffering, may be contacted at voice phone: (609) 882-7677; New Jersey TTY relay 1-800-852-7897; TTY phone (609) 882-7177. Another good source of information is Substance and Alcohol Intervention Services for the Deaf (SAISD) in Rochester, NY. Their telephone number is (716) 475-4978 (voice

and TDD). SAISD staff member, Sue Viola, was often in touch with me providing good information and ideas throughout the term.

From Sue I learned that the American Sign Language 12 Steps of AA need the following statements attached:

*This ASL Translation of the 12 Steps of A.A. is for signing purposes only.

*The Twelve Steps, both the standard version and the ASL version, are reprinted with permission of Alcoholics Anonymous World Services, Inc. Permission to reprint this material does not mean that A.A. has reviewed or approved the contents of this publication, not that A.A. agrees with the views expressed herein. A.A. is a program of recovery from addiction only-use of the Twelve Steps in connection with programs and activities which are patterned after A.A., but which addresses other problems, or in any other non-A.A. context, does not imply otherwise.

Sue Viola of SAISD recommends the following:

James, Frank & Lala, John Jr., *Counseling the deaf substance abuser*, ISBN: 0-9663753-0

Student responses to having heard Steve Shevlin speak show the intense impact his presentation produced.

Today I learned more about communication with the hearing impaired, and the struggles that you have to overcome. Right now I feel that Steve has a lot to share, and I am grateful that I got to hear his story. Next time I hope that more people will understand what the hearing impaired go through, and will make more of an effort to make things for them a little easier.

Today I learned: I was really amazed by the vast knowledge that you brought to the class. I think I learned a little bit of deaf culture. Right now I feel : I am more motivated to try and advocate. I am so honored that you came to the class and spoke

about your personal life. Next time I hope: I hope that you continue with the stuff your are doing. I think more individuals need to be aware of the deaf culture and provide more services for this culture. Thank you so much for allowing me to learn and grow more. You have definitely added to my knowledge and have really made me more want to help.

Today I learned about what it is like to be deaf and to be in recovery. I learned that there are many challenges that this population faces in getting help to recover from an addiction. Right now I feel that more needs to be done to help this population, more services need to be offered for this group of people. Next time I hope I learn about more of the services that are offered to this group of people, and that I have developed skills in working with the deaf and hard of hearing.

Today I learned the difficulties that the deaf community has with getting help with addictions and that communication is a major barrier. Right now I feel hopeful that there is help but saddened that there is not enough. I am also glad that I was able to hear this presentation. A person gains so much from life stories. Next time I hope that the class opens up more, including myself, so that more can be gained by the interaction.

Today I learned a lot new in communication with the deaf. Today I feel inspired by Steve, because I as well have a disability. I am visually impaired, so I know the struggles one faces with a disability. I hope I see you again.

Today I learned so much that I am almost speechless. The strength, determination, confidence, will power- I can go on forever- is something that I admire in you Steve. I feel very privileged that you shared your experiences and story with us. There are so many things I could ask, but I don't even know where to begin. Next time I hope: In the future I would like to take classes on sign language. I was always interested in it. I find it so fascinating. Listening and even more so, watching you today has allowed me to want to go out today and sign up for a class. Thank you very much for sharing with us today. I have gained so much from your amazing insight and views on life and living.

Today I learned that being deaf is not necessarily a negative thing. Something that would normally be seen as bad helped and made recovery possible. I never looked at being deaf in that way. It is incredible to me to see someone take the disability and turn it into a positive thing-not many can do that. Right now I feel extremely inspired. I also feel hopeful knowing that it is possible to become sober while being deaf. I feel like I am extremely lucky to have heard you speak. You have really made me look at my life and what I have to be thankful for. Next time I hope I remember you and your story and relate that to all I learn and what happens. If I could have half your strength and positive attitude I would be extremely lucky.

Today I learned how ignorant I've been in regard to the deaf population. You have really opened my eyes to a whole different world, which after listening to you I find very fascinating. Right now I feel that I would like to learn more about the deaf and their struggles and breakthroughs. I am also amazed at all the obstacles you've overcome & I give you a lot of credit for everything you've accomplished. I also truly feel you have a guardian angel watching over you-you're a very lucky man. Next time I hope... well, I hope that the next time you talk to a group of people, or even one individual, that they come away from hearing you feeling the same way I feel now. You've given us the gift of your story & I thank you for sharing it with us.

Today I learned a little bit what it would be like to work with a deaf client-some strategies and techniques to use. Right now I feel - a little overwhelmed, but I am very glad that I have had the opportunity to hear your story. It gave me a lot of hope that people can change. Next time I hope... to be able to communicate more. Today I just wanted to take every thing in. Hopefully next time I will be more confident and comfortable to take part in the conversation.

Today I learned how challenging the barriers can be for sobriety within the deaf community. Right now I feel sort of overwhelmed at the difficulties I would have in communicating with the hard of hearing, but also grateful to gain a new perspective. Next time I hope that I will be more comfortable and will learn ASL or some form of communication with the deaf population.

Today I learned the struggles the deaf community has. Right now I feel great admiration for Steve. Next time I hope to ask more questions.

Today I learned what it is like to be deaf as an adult, and be an addict and the challenges a person goes through. Right now I feel that I wish more people were experienced and willing to be open to working with deaf/chemically addicted clients. I feel more comfortable, and have a better understanding, and know the challenges, but am not afraid of them. Next time I hope to learn how to go about treating and engaging this population.

Today I learned that clients with hearing difficulties along with addiction issues have many more challenges than clients without those problems. I also learned that hearing impaired clients will clue in on your physical actions much more than clients without hearing impaired problems. Right now I feel grateful that I had a chance to hear you speak about your life and experiences. Next time I hope that I will have more understanding when I work with clients who are hearing impaired along with addictions problems. I will have a better understanding of what the clients' needs are and how I can better support them.

Today I learned that the deaf community is in need of many supports that may be greatly overlooked by society. Right now I feel a sense of inspiration from Steve's story and it has caused me to take a look at life from a more positive perspective. Next time I hope to hear more about this topic.

ATOD RISK FACTORS for PERSONS with DISABILITIES

1. ACCESS to PRESCRIPTION MEDICATIONS

2. SELF MEDICATION

3. OPPRESSION: ISOLATION AND DISCRIMINATION

4. IATROGENIC ADDICTION - PRESCRIBED ADDICTIVE SUBSTANCES

COMMUNICATION
B. PERSONAL CARE
C. TOOL USE
D. MOBILITY
MOVEMENT

Adapted from: Hepner, R., Kirshbaum, H., & Landes, D. (1981). Counseling substance abusers with additional disabilities: the center for independent living. *Alcohol Health and Research World, (5)*, 11-15.

BARRIERS to SUCCESSFUL TREATMENT for PWD

1. **PROFESSIONAL RESPONSES: PITY, FEAR, GUILT, LOW EXPECTATIONS**

2. **INACCESSIBLE TREATMENT:**

   A. **LACK OF PROFESSIONAL TRAINING**
   B. **LACK OF SPECIALIZED TREATMENT**
   C. **LACK OF SPECIALIZED GROUP SUPPORT**
   BUILDINGS AND FACILITIES NOT ADAPTED FOR USE

3. **ENABLING SYSTEMS**

4. **CRIMINAL JUSTICE SYSTEM BABIES DISABLED**

5. **TRANSPORT PROBLEMS**

6. **LACK OF JOB RELATED INCENTIVE**

7. **DISJOINTED PROGRAMING**

8. **PERSONAL PSYCHOLOGICAL BARRIERS: manipulation of staff**

Adapted from: Geekie, K.M. & Brown, H. P. (1995). Treating substance abuse in the multi disabled: An overview. *Alcoholism Treatment Quarterly, 12*, 87-95.

ADOLESCENTS WITH DISABILITIES
ATOD RISK

1. **Medical factors**

2. **Etiology of disability: Caused by ATOD use?**

3. **Social Psychological factors: disenfranchisement, isolation**

4. **Attitudinal, demographic, behavioral developmental challenges related to disability:**
    a. **severity of disability - how much social interaction outside family**
    b. **the disability - pain, tiredness**
    c. **visibility of disability**
5. **History of:**
    a. **negative feelings toward school**
    b. **negative disruptive behaviors**
    c. **few activities attended**
    d. **low grade average**

From: Kessler, D. T. & Klein, M. A. (1995). Drug use patterns and risk factors of adolescents with physical disabilities. *International Journal of the Addictions, 30*, 1243-1270

MEDIATING FACTORS: ADOLESCENTS AND ATOD USE

Information on ATOD

Identifying and counteracting peer, adult and media Influences

Learning resistance skills and norm setting

Making a commitment not to use ATOD

Involvement in non-ATOD activities

Increasing decision making and goal setting skills

Increase self worth

Learning assertiveness skills

Non-drug peer involvement

From: Kessler, D. T. & Klein, M. A. (1995). Drug use patterns and risk factors of adolescents with physical disabilities. *International Journal of the Addictions, 30*, 1243-1270.

Student feedback and other outcomes:

Along with end of class responses, students produced summary papers and group projects that included presentations. Students wrote response papers after attending AA meetings. These came at the beginning of the term and indicated that a number had now attended their first AA meeting. Unless they traveled with a friend who is an AA member, the students were instructed to attend open meetings and to state that they were "here to learn." They were to be honest and were not to take notes or in any way violate the confidentiality of persons attending the meeting. They respected these guidelines, and I did not see violations of privacy. The students benefited by attending. Now they know enough about AA to take a client to a meeting or to appreciate avenues of help for themselves or others.

Group papers were of a reasonably good quality and indicated that students had taken assignments seriously. They had worked together and had written in acceptable ways. There were no complaints of groups members slacking or letting others do all the work. Group projects and presentations were seemingly difficult to produce. The material was new to the students. They had a hard time finding ways to dig deeper into an area and carry it further than we had traveled in class. Presentations were finally completed and included verbal discussion, skits, overhead foils, handouts, and other materials along with a brief term paper. I will reconsider this assignment next time I teach the course. Final grades for the course ranged from 80 to 95%.

All students who remained in the course at the beginning completed the course and received a certificate stating that they have completed 45 hours toward the credential for the alcohol and substance abuse counselor and that the course approval is pending. The course will be submitted for evaluation by OASAS. Marist College has been an educational provider for the credential. A re-accrediting process is in

place, and Marist will reapply and submit this course for consideration.

At the end of the term, students completed standard course evaluations that have become available to me. Of the sixteen students who completed the formal course evaluation, eight said the guest speakers were the highlight of the course. The reading materials received average rather than high marks from ten of the sixteen students. Seven of the sixteen students, or forty-four percent, rated their learning in the course at the highest level, "a great deal." Eight others or fifty percent rated their learning at the next highest level, "much." Only one student claimed to have learned "an average amount." Five students rated the work load for the course "heavy" and thirteen rated the load "average" for Marist College.

To conclude, this course was an adventure for all of us! I am thankful to have had the opportunity to teach the course just as Martha Mashburn, Mary Phillips and I envisioned last summer. We all learned! I am looking forward to developing he course for 2000. The presenters have all agreed to return for one session. Students will walk through new doors of hope and insight. Thank you ATTC for making this adventure possible.

MARIST COLLEGE
Poughkeepsie, NY

Dennis J. Murray, Ph.D.
President

Artin Arslanian, Ph.D.
Dean of the Faculty

This is to acknowledge that

_____

has satisfactorily completed 45 hours of
Alcoholism Training
Addictions and Special Populations:
Mentally ill, intellectually impaired,
and physically challenged
Cheryl Whitley, CSW, R, Ph.D.
MAY 1999

Margaret R. Calista, CSW, Chair
Social Work Program

William Eidle, Ph.D., Dean
School of Social and Behavioral Sciences

Application for credits toward the Certified Alcoholism and Substance Abuse Counselor credential has been made to the Office of Alcoholism and Substance Abuse Services